



Arizona Institute  
of Medicine & Pediatrics

## ADULT CONFIDENTIAL PERSONAL HEALTH HISTORY

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Please answer the following questions completely and to the best of your ability. If you are not certain of the appropriate response to a question, please discuss it further with your physician. If the answer is "none", circle NONE.

### PRIMARY CONCERNS FOR THIS OR FUTURE APPOINTMENTS:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

### ALLERGIES/ MEDICATION REACTIONS: NONE

| MEDICATION NAME | DESCRIBE REACTION |
|-----------------|-------------------|
|                 |                   |
|                 |                   |
|                 |                   |

### PAST MEDICAL HISTORY: NONE (CHECK ALL CONDITIONS OR SYMPTOMS YOU HAVE HAD DIAGNOSED OR TREATED)

| CONDITION                                      | ONGOING?                                                 | DATE BEGAN | CONDITION                                    | ONGOING?                                                 | DATE BEGAN |
|------------------------------------------------|----------------------------------------------------------|------------|----------------------------------------------|----------------------------------------------------------|------------|
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Angina                | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Kidney Failure      | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Arthritis, Osteo.     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Arthritis, Rheumatoid | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Lupus               | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Atrial Fibrillation   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Ovary Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Bleeding Disorder     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Pancreatitis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Cancer: _____         | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Poor Circulation    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Cataracts             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Prostate Problems   | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Chronic Back Pain     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Chronic Bronchitis    | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Chronic Diarrhea      | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Colon Polyps          | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Sexual Dysfunction  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Shingles            | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Crohn's Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Skin Lesions        | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Stomach Ulcers      | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Eating Disorder       | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Testicular Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Gallstones            | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Ulcerative Colitis  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Gout                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Valley Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Headaches             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Vision Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |
| <input type="checkbox"/> Hearing Loss          | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      | <input type="checkbox"/> Other (list all):   |                                                          | _____      |
| <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |                                              |                                                          | _____      |
| <input type="checkbox"/> Heart Failure         | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |                                              |                                                          | _____      |
| <input type="checkbox"/> Heartburn             | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |                                              |                                                          | _____      |
| <input type="checkbox"/> Hemorrhoids           | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |                                              |                                                          | _____      |
| <input type="checkbox"/> Hepatitis _____       | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____      |                                              |                                                          | _____      |



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**LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS: NONE**

| SURGERY/HOSPITALIZATION | PHYSICIAN/SURGEON | MONTH/YEAR |
|-------------------------|-------------------|------------|
|                         |                   |            |
|                         |                   |            |
|                         |                   |            |
|                         |                   |            |
|                         |                   |            |

**LIST CURRENT MEDICATIONS: NONE**

\*\*\* Including over-the-counter medications, such as vitamins, pain relievers, laxatives, and naturopathic preparations such as herbs and teas.

| MEDICATION NAME | STRENGTH OR DOSE | FREQUENCY |
|-----------------|------------------|-----------|
|                 |                  |           |
|                 |                  |           |
|                 |                  |           |
|                 |                  |           |
|                 |                  |           |
|                 |                  |           |
|                 |                  |           |
|                 |                  |           |
|                 |                  |           |
|                 |                  |           |

**LIST ALL HEALTHCARE PROVIDERS WHO HAVE TAKEN CARE OF YOU IN THE LAST THREE (3) YEARS: NONE**

| PHYSICIAN NAME | SPECIALTY/YEAR | CITY/STATE | CONDITION TREATED |
|----------------|----------------|------------|-------------------|
|                |                |            |                   |
|                |                |            |                   |
|                |                |            |                   |
|                |                |            |                   |
|                |                |            |                   |

**FAMILY HISTORY: NONE** (LIST ALL CHRONIC MEDICAL CONDITIONS IN THE IMMEDIATE FAMILY)

|                             |                        |
|-----------------------------|------------------------|
| Arthritis, Osteo _____      | Diabetes _____         |
| Arthritis, Rheumatoid _____ | Heart Attack _____     |
| Asthma _____                | Hypertension _____     |
| Blood Clots _____           | High Cholesterol _____ |
| Cancer, Breast _____        | Lupus _____            |
| Cancer, Colon _____         | Stroke _____           |
| Cancer, Skin _____          | Thyroid Problems _____ |
| Cystic Fibrosis _____       | Other _____            |
| Depression _____            | Other _____            |

**SOCIAL/DEVELOPMENT HISTORY:**

|                                  |                         |                       |
|----------------------------------|-------------------------|-----------------------|
| Birthplace: _____                | Years in Arizona: _____ | Winter Visitor? _____ |
| Marital Status: _____            | Hobbies: _____          |                       |
| Occupation: _____ Retired? _____ | Pets: _____             |                       |

**YEAR OF LAST INJECTION OR TEST:**

|                                |                           |                               |
|--------------------------------|---------------------------|-------------------------------|
| _____ Bone Scan (Osteoporosis) | _____ Flu Vaccine         | _____ Pulmonary Function Test |
| _____ Cardiac Catheterization  | _____ Hepatitis A Vaccine | _____ Sigmoidoscopy           |
| _____ Chest X-ray              | _____ Hepatitis B Vaccine | _____ Stool for Occult Blood  |
| _____ Cholesterol Test         | _____ MMR Vaccine         | _____ TB Skin Test            |
| _____ Colonoscopy              | _____ Pneumonia Vaccine   | _____ Tetanus Vaccine         |
| _____ EKG                      | _____ PSA Test            | _____ Treadmill for Heart     |



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**SYSTEM REVIEW: (CIRCLE ANY SYMPTOM YOU CURRENTLY HAVE, OR THAT HAS BEEN A RECURRING PROBLEM)**

**DO YOU WEAR ANY OF THE FOLLOWING?**

- Dentures
- Hearing Aids
- Glasses
- Contact Lenses

**GENERAL:**

- Dizziness
- Excess Thirst
- Fainting
- Fatigue
- Fevers
- Mood Swings
- Sleep Problems
- Weight Gain
- Weight Loss
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**SKIN INTEGUMENT:**

- Bruising
- Eczema
- Hives
- Itchiness
- Moles
- Psoriasis
- Rashes
- Other: \_\_\_\_\_

**HEAD AND NECK:**

- Blurred Vision
- Dental Pain
- Double Vision
- Ear Ringing
- Eye Infections
- Eye Pain/Floaters
- Jaw Pain
- Hayfever
- Headaches
- Head Injury
- Hearing Loss
- Hoarseness
- Mouth Sores
- Neck Pain
- Lymph Nodes
- Neck Swelling
- Nosebleeds
- Sinus Infections
- Sore Throats
- Other: \_\_\_\_\_

**GASTROINTESTINAL:**

- Abdominal Pain
- Black/Tarry Stool
- Bloating/Gas
- Blood in Stool
- Change in Bowels
- Constipation
- Diarrhea
- Hard to Swallow
- Heartburn
- Loss of Appetite
- Painful Swallowing
- Persistent Nausea
- Vomiting
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**PULMONARY:**

- Blood in Sputum
- Cough
- Wheezing
- Other: \_\_\_\_\_
- Shortness of Breath Lying Down
- Shortness of Breath on Exertion
- Shortness of Breath at Rest
- Other: \_\_\_\_\_

**CARDIAC/CIRCULATION:**

- Angina
- Chest Pain
- Chest Pressure
- Chest Tightness
- Irregular Pulse
- Leg Pain on Walking
- Murmur
- Palpitations
- Swollen Ankles
- Varicose Veins
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**GENITOURINARY:**

- Blood in Urine
- Increased Urine Frequency
- Genital Discharge
- Sexual Dysfunction
- Decreased Urine Control
- Painful Urination
- Decreased Urine Stream
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**NERVOUS SYSTEM:**

- Anxiety/Nervousness
- Chronic Pain
- Depression
- Knocked Unconscious
- Memory Loss
- Mental Illness
- Numbness/Tingling
- Phobias
- Seizures
- Tics
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**MUSCULOSKELETALS:**

- Joint Pain
- Muscle Weakness
- Joint Swelling
- Muscle Pain
- Joint Deformity
- Muscle Wasting
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_



HEALTH RISK ASSESSMENT:

CAFFEINE USE: NONE Indicate the amount of coffee and tea taken per day: \_\_\_\_\_ Indicate the amount of soft drinks taken per day: \_\_\_\_\_

Table with columns: ALCOHOL USE: NONE, NEVER, MONTHLY, 2-4X PER MONTH, 2-4X PER WEEK, DAILY. Rows include questions about drinking frequency, injury, and alcohol dependence.

TOBACCO USE: NONE Have you smoked cigarettes? Yes No Began: \_\_\_ Packs/day: \_\_\_ Quit: \_\_\_ Have you used other tobacco products... Have any of your roommates smoked...

DRUG USE: NONE Have you used IV drugs? Yes No Are you still using IV drugs? Yes No Have you used marijuana? Yes No Are you still using marijuana? Yes No Have you used cocaine? Yes No Are you still using cocaine? Yes No Have you used crystal? Yes No Are you still using crystal? Yes No

HIV/AIDS RISK: Have you ever had a blood transfusion? Yes No If yes, what year(s)? Have you used intravenous drugs within the last 10 years? Yes No Have you engaged in unprotected sex within the last 10 years? Yes No Have you had multiple sexual partners within the last 10 years? Yes No

OTHER HEALTH BEHAVIORS: Do self-breast/testicular exams? Yes No Exercise regularly? Yes No Wear seat belts regularly? Yes No Limit cholesterol in your diet? Yes No Routinely wear sun protection? Yes No Visit a dentist annually? Yes No Visit an optometrist annually? Yes No Have a smoke detector in your home? Yes No

GYNECOLOGIC HISTORY: (FOR FEMALES ONLY)

Age at onset of menses: \_\_\_ years Date of last menstrual period: \_\_\_ Length of montly cycle: \_\_\_ days Cycle is/was: Regular Irregular Length of menstruation: \_\_\_ days Flow is/was: Light Moderate Heavy Age at menopause: \_\_\_ years Menopause was: Natural Surgical Number of: Pregnancies \_\_\_ Live Births \_\_\_ Miscarriages \_\_\_ Abortions \_\_\_ Date of last PAP smear: \_\_\_ Date of last mammogram: \_\_\_ Have you ever had an abnormal PAP smear? Yes No If yes, when? \_\_\_ Have you ever had an abnormal mammogram? Yes No If yes, when? \_\_\_

PSYCHOLOGIC HISTORY: Please indicate if you now have or in the past have ever experienced the following:

C= CURRENT P= PAST N= NONE

Depression: \_\_\_ Mania/ Psychosis \_\_\_ Sexual Abuse \_\_\_ Physical Abuse \_\_\_ Suicidal/ Homicidal Thoughts \_\_\_

I have answered all of the questions in this confidential questionnaire as honestly, accurately, and completely as I can.

PATIENT'S SIGNATURE

DATE