Qliance

Health History Form
Adult

NAME:	DOB: *mm/dd/yyyy*	DATE:

HEALTH ASSESSMENT

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What is most important to you about your medical care? *(e.g. communication, prevention, wellness planning)*
What specific concerns would you like to address with your new clinician?

MEDICATIONS & ALLERGIES

Please list all your current medications and allergies *(including vitamins & supplements).*

Item	Dose	Frequency	Taken for	Prescribed by
1.				
2.				
3.				
4.				
5.				

Allergies to medication and other items:

1.	Reaction:	
2.	Reaction:	
Preferred pharmacy:	Phone:	Fax:
Address:		

PERSONAL MEDICAL HISTORY

Have you ever had any problems with the following: *(If yes, please explain.)*

☐ Alcohol or substance abuse:			☐ Metabolism *(diabetes, thyroid etc.)*		
☐ Blood:			☐ Muscle, joint, bones:		
☐ Cancer:			☐ Nerves and brain:		
☐ Digestion:			☐ Skin and hair:		
☐ Ear, nose, throat, eyes:			☐ Sleep:		
☐ ER Visits:	Type:	Date:	☐ Social, mental or emotional health:		
☐ Heart or blood vessels:			☐ Surgeries:	Type:	Date:
☐ Hospitalizations:	Type:	Date:	☐ Women's health:		
☐ Kidneys or bladder:			Pregnancies (#):	Births (#):	Living Children (#):
☐ Lungs:			Other:		
☐ Men's health:					

FAMILY MEDICAL HISTORY

Please indicate any family members who have had the following:

☐ Alcohol abuse:	☐ Bleeding disorders:	☐ Deafness:
☐ Arthritis:	☐ Breast cancer:	☐ Dementia:
☐ Asthma:	☐ Cancer of an unknown type:	☐ Depression:
☐ Autism:	☐ Colon cancer:	☐ Diabetes:

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NAME:	DOB:

Family Medical History Continued

☐ Bipolar disorder:	☐ Cystic fibrosis:	☐ Glaucoma:
☐ Heart attack:	☐ Lymphoma/Leukemia:	☐ Schizophrenia:
☐ Heart disease:	☐ Osteoporosis:	☐ Sickle cell anemia:
☐ High blood pressure:	☐ Ovarian cancer:	☐ Skin cancer:
☐ High blood cholesterol:	☐ Obesity:	☐ Stroke:
☐ HIV:	☐ Parkinson's disease:	☐ Substance abuse:
☐ Inherited anemias *(i.e. thalassemia):*	☐ Prostate cancer:	☐ Thyroid:
☐ Inflammatory bowel disease *(e.g. Crohn's disease):*		☐ Other cancer:
☐ Any other condition that two or more relatives have?		

SOCIAL HISTORY & LIFESTYLE

Relationship status: O Married or Partnered O Single O Separated O Divorced O Widowed

What is your highest level of education? Occupation:

Do you have any children? O Yes O No

Name:	DOB:	Lives at home? O Yes O No
Name:	DOB:	Lives at home? O Yes O No

Who also lives at home with you?

Do you have any pets? O Yes O No

Have you ever been neglected or abused, physically, emotionally or sexually?

If yes, are you currently living in an unsafe situation? O Yes O No

Do you have more than one sexual partner? O Yes O No

Sexual Partners: O Men O Women O Both O None

Do you practice safer sex? *(i.e. use condoms)* O Yes O No

What are you using for birth control?

On average, how many alcoholic drinks do you consume per week?

In the past year, how many times have you had more than 4 (females), 5 (males) drinks in one day?

Do you use or have you ever used tobacco products?

Does anyone smoke around you?

Do you use or have you ever used recreational drugs? O Yes O No

How much caffeine do you consume daily? *(coffee, soda, chocolate etc.)*

Do you have concerns about your diet? O Yes O No

What do you do for exercise?

Do you have: O A living will O Power of attorney O Durable power of attorney for health care

HEALTH MAINTENANCE & PREVENTION

When was the last time you:

Visited the dentist:	Had a Tetanus booster:
Had a blood sugar test:	Had a cholesterol test:
Had a colon cancer screening:	

Type: O Colonoscopy O Flexible sigmoidoscopy O Occult blood stool test *(card)*

Women's Health

When was your last: PAP smear? Mammogram? Bone density test?

Men's Health

When was your last: Prostate exam?

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