ADULT HEALTH HISTORY FORM – RACHEL RUBIN-TOLES, MD

NAME: (Last, First, Middle) ____ DOB ________________

Address: ____

Home Phone: _________________ Cell Phone: _________________ Work Phone: ______________

Occupation: _________________________________ Marital Status: S__ M__ D__ W__

Please list all ALLERGIES to medications and your reaction to that medication:

____
____
____
____
____

Please list all medications you are currently taking. Be sure to include PRESCRIPTION medications and OVER THE COUNTER medications such as aspirin, multi-vitamins etc.

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VACCINATION HISTORY: Please list the year of your last vaccination. If you have never received a particular vaccination, write "NA" for "not applicable.

Tetanus _________________ Flu _________________ Pneumonia ___________________

PERSONAL MEDICAL HISTORY: Please list all conditions which you currently have or have had in the past:

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____

Please list all HOSPITLIZATIONS and SURGERIES within the past five years, the approximate dates, hospital name and the reason for the hospitalization or surgery.

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FAMILY MEDICAL HISTORY: Please check whether a family member currently has or had any of the following conditions and if on maternal (mother's side), or paternal (father's side), and specify how they are related to you.

Condition	Yes	No	Explanation
Digestive/Nutrition			
Ears/ Hearing			
Urine / Kidneys			
Joints			
Skin			
Lungs			
Teeth			
Heart			
Seizures			
Repeated Infections			
Heart Disease			
Tuberculosis			
High Blood Pressure			
Kidney Disease			
Allergies/Asthma			
Cancer			
Diabetes			
Mental/emotional Problems			
Sickle Cell			

LIFESTYLE HABITS: Please answer the following questions:

Have you ever used tobacco products? YES _____ NO ____ if you are currently using tobacco products, how much do you use and for how long have you been doing so?

____

____

If you no longer use tobacco products, when did you quit and how much did you use?

____

____

Do you consume Alcohol? YES _____ NO _____ If yes, about how many drinks per week? _________

Do you exercise routinely? YES ______ NO _____ If yes, what type of exercise and how often?

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Reviewed by: ____ Date: __________________________