

Patient Name: _____ Gender Identity: M F Legal Sex: M F DOB: _____
 Address: _____ Marital Status: _____
 Phone: _____ Email: _____
 Emergency contact name: _____ Phone: _____

HEALTH HISTORY									
Do you or have you experienced the following:									
Anemia	Y	N	Heart Problems	Y	N	Mitral Valve Prolapse	Y	N	
Anxiety Disorder	Y	N	Hepatitis	Y	N	MRSA	Y	N	
Blood Transfusion	Y	N	High Blood Pressure	Y	N	Osteoporosis	Y	N	
Cancer	Y	N	Hyperthyroid	Y	N	Seizures	Y	N	
Depression	Y	N	Hypothyroid	Y	N	Stress Incontinence	Y	N	
Diabetes	Y	N	Lupus	Y	N	Stroke	Y	N	
Other: _____						Abnormal Pap	Y	N	
If yes above, explain: _____									

HOSPITALIZATIONS / SURGERIES / DIAGNOSTIC TEST			
Hospitalization / Surgery / Diagnostic Test	Date	Hospitalization / Surgery / Diagnostic Test	Date

SOCIAL HISTORY	
Second hand smoke exposure <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No Packs or Cans Per Day _____ For How Long? _____ Date Quit _____	
Alcoholic Beverages Amount _____ Frequency _____ Cups of Coffee per Day _____ Pop or Tea per Day _____	
Have you used street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you used IV drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Total # of children in home _____	Total # of pregnancies _____ # of abortions _____ # of miscarriages _____ # of premature births _____
# of living children: _____	# of full-term babies: _____
How many vaginal births have you had: _____	How many cesarean births have you had: _____
Any complications of pregnancy: _____	
Are you afraid of anyone at home? <input type="checkbox"/> Yes <input type="checkbox"/> No	

FAMILY HISTORY			
Do your blood relatives have any of the following: (Please note which relative and whether Maternal (mother) or Paternal (father)).			
	Relationship		Relationship
Cancer _____	Y N _____	MRSA	Y N _____
Cancer _____	Y N _____	Heart Disease	Y N _____
Blood Clotting Disorder	Y N _____	High Blood Pressure	Y N _____
Diabetes	Y N _____	Osteoporosis	Y N _____
Other: _____		Stroke	Y N _____

Bryan Physician Network

Adult Health History Form



