Teton
Vascular Institute

Adult Health History

Name	Date of birth	Date

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best answer. Thank you.

Main reason for today's visit

Other concerns

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Primary care provider

Review of Systems *Have you ever had any of the following (check all that apply)*

Constitutional

☐ Unexplained weight loss/gain

☐ Recent fever/sweats

☐ Unexplained fatigue/weakness

☐ Recent chills/cold sweats

Cardiology

☐ Chest pains/discomfort

☐ Palpitations

☐ Decreased exercise tolerance

Dermatology

☐ Rash

☐ New or change in mole

Endocrinology

☐ Cold/heat intolerance

☐ Increase thirst/appetite

ENT

☐ Change in hearing

☐ Congestion

☐ Sinus pain

☐ Sore throat

Hematology/Lymph

☐ Unexplained lumps

☐ Easy bruising/bleeding

Genitourinary

☐ Painful/bloody urination

☐ Leaking urine

☐ Night time urination

☐ Discharge: penis or vagina

☐ Concern with sexual functions

Gastroenterology

☐ Heartburn/reflux

☐ Bloody stools

☐ Change in bowel movement

☐ Nausea/vomiting/diarrhea

☐ Pain in abdomen

Musculoskeletal

☐ Muscle/joint pain

☐ Recent back pain

☐ Weakness

☐ Swollen joints

Neurology

☐ Memory loss

☐ Headaches

☐ Fainting

☐ Numbness/tingling in hands/feet

☐ Loss of balance

Ophthalmology

☐ Change in vision

☐ Eye pain

Psychology

☐ Anxiety/stress

☐ Sleep problems

Respiratory

☐ Cough/wheeze

☐ Coughing blood

☐ Short of breath with exertion

☐ Pain with breathing

Women

☐ No periods

☐ Heavy periods

☐ Painful periods

☐ Irregular periods

☐ Unusual vaginal bleeding

Date of last period:

_____

Menopause age:

_____

In the past month have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?

☐ Yes ☐ No

Do you have an Advanced Care Plan (Living Will)

☐ Yes ☐ No

Who is your surrogate decision maker?

Name: ☐ None

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Allergies *Do you have allergies or reactions to the following, please list*

Medications	Reaction	Foods	Reaction

Medication

Prescriptions and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day	Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day

Medical History

Major illnesses: (i.e., high blood pressure, high cholesterol, depression, etc.)	Year of diagnosis	Doctor treating
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Surgeries

Surgeries	Year of surgery	Reason for surgery
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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Adult Health History

Family History	
Mother ☐ Living ☐ Deceased	Ailments
Father ☐ Living ☐ Deceased	Ailments
# brothers alive: _____ # brothers deceased: _____	Ailments
# sisters alive: _____ # sisters deceased: _____	Ailments
# children alive: _____ # children deceased: _____	Ailments

Social History

Tobacco use

Cigarettes ☐ Never ☐ Quit date: _____ ☐ Current smoker: _____ packs/day; # of years _____

Other tobacco; ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol use

Do you drink alcohol? ☐ Yes ☐ No # drinks/week _____

Is alcohol use a concern for you or others? ☐ Yes ☐ No

Are you satisfied with your weight? ☐ Yes ☐ No	How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Socioeconomics

Occupation

Employer

Marital status

☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed

Women Health History			
# Pregnancies	# Deliveries	# Abortions	# Miscarriages

Exercise		
Do you exercise regularly? ☐ Yes ☐ No	If you do not exercise, why not?	
If yes, what kind of exercise:	How long (minutes)	How often?

Signature	
Patient signature	Date

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