CHAPA-DE
INDIAN HEALTH

Today's Date: _____

Pt. Acct. #: _____

DOB: _____

ADULT HISTORY FORM

Your answers on this form will help your medical team understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer. Best estimates are fine if you cannot remember specific details. *Thank You!*

HABITS

What do you do for exercise? Please Explain:

How often do you exercise? ____ hours per week

Do you wear sunscreen? ❑ Yes ❑ No ❑ Sometimes

Wear seatbelts/helmets? ❑ Yes ❑ No ❑ Sometimes

Do you have any trouble sleeping? ❑ No ❑ Yes

Do you take anything to sleep? ❑ No ❑ Yes

IMMUNIZATIONS (please list your best estimate of when you received these vaccinations)

Immunization	MM/YY	Immunization	MM/YY	Immunization	MM/YY
Hepatitis A		MMR		Varicella (chicken pox)	
Hepatitis B		Measles		PCV 13	
HPV		Mumps		Pneumovax (Pneumonia)	
Tetanus (Td)		Rubella		Shingles	
TdaP		Meningitis		Other:	

SOCIAL HISTORY

Education completed (check one):

❑ Grade School ❑ High School

❑ College ❑ Graduate School

Work Type:

Are you retired? ❑ Yes ❑ No ❑ Partially

Do you enjoy your job? ❑ Yes ❑ No

Any major stresses in your life?

Are you sexually active?

❑ Yes, current sexual partner(s) is/are:

❑ No

❑ Not Currently

❑ Male ❑ Female ❑ Both

Relationship Status:

❑ Married ❑ Single ❑ Widowed

❑ Divorced/Separated ❑ In a relationship

How long in relationship?

Number of children:

Who lives with you?

My Current Health Concerns:

My Health Care Goals:

REVIEW OF SYMPTOMS (please circle any *current* problems you have on the list below)

GENERAL SYMPTOMS
Fever, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out

EYES
Vision loss, eye pain, blurred vision, change in vision

EARS/NOSE/MOUTH & THROAT
Sore throat, runny nose, hearing loss, problems with mouth, voice changes, hay fever, allergies

BREAST
Lumps, skin changes, nipple discharge, pain

SKIN
Rashes, changing moles, changes in hair, skin or nails, itching

MUSCULOSKELETAL
Joint or muscle pain, muscle weakness

ABDOMEN
Nausea, vomiting, pain, heartburn, diarrhea, constipation, bloody stools

NEUROLOGICAL
Unusual or new headaches, weakness or numbness, falling, memory loss, loss of coordination, migraines

LUNG & HEART
Chest pain or pressure, irregular heartbeat, cough, wheezing, breathing trouble, palpitations

SLEEP
Difficulty falling asleep, frequent awakening, snoring, apnea

MOOD
Worry too much, felt down and depressed in the last two weeks, loss of desire to do thing you enjoy

MEN ONLY
Difficulty starting or weak stream, difficulty getting or maintaining erections, feeling like bladder wont empty, getting up at night to urinate, testicular pain or lumps, possible sexually transmitted infections, blood in urine

WOMEN ONLY
Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, leaking urine, blood in urine

Still having periods? ❑ Yes ❑ No
Date of last period: _____
Birth control type:_____

Hysterectomy? ❑ Yes ❑ No
If yes, at what age? _____

Number of pregnancies: _____

- Vaginal Deliveries _____
- C-Section Deliveries _____
- Other _____

(stillbirth, miscarriage, abortion)
Diabetes in pregnancy? ❑ Yes ❑ No

Have you ever had an abnormal PAP or colposcopy? ❑ Yes ❑ No