Date_____

HALEIWA FAMILY HEALTH CENTER
ADULT HEALTH HISTORY
10 Years and Older

NAME_____SEX_____BIRTH DATE_____
PREVIOUS MEDICAL CARE_____PLACE OF BIRTH_____
Clinic/Doctor's Name

MEDICAL HISTORY

1. List any past or present medical conditions, with dates:

2. List any past hospitalizations:
   When (year or age) What Hospital Reason

3. List any previous surgeries:
   When (year or age) What Hospital Type of surgery

4. List any allergies (include medications, foods, plants, insects, etc.):

5. Last doctor visit? _____ Last immunization (Pneumovax) _____
   Last TB skin test _____ Pos/Neg (Flu shot)_____
   For women: Last pap smear _____ (Tetanus booster)_____
   Last mammogram _____ (Hepatavax)_____

FAMILY HISTORY

1. Circle if present Diabetes / High blood pressure / Heart Disease / Stroke
   In close family: Tuberculosis / Cancer / Gout / Asthma / Allergy / Heart Attack
   Anemia / Kidney Disease / Epilepsy / Bleeding problems / Arthritis

2. Father's age _____ Health _____ If deceases, age and cause_____
   Mother's age ____ Health _____ If deceased, age and cause_____

3. Number of brothers _____ Sisters _____ Ages (list): _____
   Any health problems:_____

SOCIAL HISTORY

1. Occupation _____
2. Marital status _____
   Spouse's name: _____
   Children's name: _____
3. Number of children _____
4. Religion _____
5. Race _____
6. Education completed _____
7. Who lives at home? _____
8. Do you smoke? _____
9. Do you drink alcohol? _____
10. Advance directives? _____

Please list all medications you are now taking (including aspirin, cold tablets, birth control pills, etc):