Senior Adults Specialty Healthcare: Health History Information Sheet

Date: _____

Patient Name: _____ **Date of birth:** _____

Background/Social Information

Age: _____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
If married, how long? _____
If divorced or widowed, how long? _____
Where do you live? ___ own home ___ apartment ___ retirement center ___ assisted living
other _____
How many children do you have (if any)? _____
How far did you go in school? _____
Are you currently employed? If so, by whom? _____
If retired, from what occupation? _____
Have you designated a power of attorney? If so, who? _____
Who referred you to us? _____
Handedness: Right or Left _____

Do you **drink alcohol** ___ Yes ___ No
How many drinks at a time? _____
Have you ever been a daily drinker? ___ Yes ___ No
If yes, for how many years? _____

Do you **smoke** ___ Yes ___ No
If yes, do you smoke Occasionally? _____ Every day? _____ Heavy Smoker?_____
If yes are you interested in learning about how to quit?_____
If NO have you never smoked or have you quit? Never_____ Quit_____

Do you **use drugs such as medical marijuana, CBD products or mushrooms?** ___ Yes ___ No
If you currently do not use these drugs have you used them in the past? _____ Yes _____ No

Have you ever been a victim of physical abuse? ___ Yes ___ No
Emotional/verbal abuse? ___ Yes ___ No
Sexual abuse? ___ Yes ___ No

Health History

Current Medications (include over the counter & herbal products)

Medication name	**dose & frequency**	**condition being treated**	**duration**

Current Medications Continued

Medication name	**dose & frequency**	**condition being treated**	**duration**

Do you have any of the following health problems?

___ Gait disorder
___ Diabetes
___ Heart Rhythm
___ Heart Attacks When? _____
___ Congestive Heart Failure
___ High blood pressure
___ History of Shingles When? _____
___ Asthma
___ Lupus
___ Low Thyroid
___ Chest Pain
___ Emphysema/COPD on Oxygen? ___ Yes ___ No
___ Macular Degeneration
___ Glaucoma
___ Seizures
___ Tuberculosis
___ Hepatitis
___ Rheumatoid Arthritis
___ History of Cancer Type _____ When? _____
___ Acid Reflux
___ Strokes When? _____
___ Cirrhosis
___ Chronic Pain
___ AIDS
___ Kidney Problems
___ Osteoarthritis
___ Sleep Apnea
___ Parkinson's
___ Essential tremors

List any other medical conditions or health problems not listed above:

_____
_____
_____
_____
_____

List any major surgeries you have had:

Surgery	Date	Complications?

Do you have any allergies or bad reactions to medications?

Medications	Symptoms	Mild, Moderate or Severe Reactions	When did it start?

Have you ever sustained an **injury to your head** such that you were knocked unconscious?

___ Yes ___ No

If yes, when did it happen and how long were you knocked unconscious?

_____
_____
_____