Holland Hospital

Adult Health History

To help facilitate your initial appointment, please complete the questions below and bring this document with you to your appointment.

Name: Date: Date of Birth:

Current Medical Conditions

Medications

Please list all of the medications that you are currently taking. Attach additional pages if needed.

Name of medication	Dosage	Number of times daily

Are you taking any of the following medications? Please check Yes or No

Medication	Yes	No
Aspirin	☐	☐
Ibuprofen (Advil®) or naproxen (Aleve®)	☐	☐
Vitamin D	☐	☐
Calcium	☐	☐
Multivitamin	☐	☐
Other vitamin or supplement	☐	☐

Name of your previous primary care physician:

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Allergies/Intolerance

Please list any medications allergies along with reaction (example: penicillin – rash). Attach additional sheets if necessary.

1. _____
2. _____
3. _____

Do you have a latex allergy? ☐ Yes ☐ No

Medical History

Please list any medical conditions.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please check any other current/past medical conditions you have not already listed above:

☐ Anemia	☐ Emphysema/COPD	☐ Liver disease
☐ Anxiety	☐ Glaucoma	☐ MRSA (staph) infection
☐ Arthritis	☐ Gout	☐ Osteoporosis/osteopenia
☐ Asthma	☐ Heart disease	☐ Sexually transmitted illness
☐ Blood clots	☐ High blood pressure	☐ Skin cancer
☐ Depression	☐ High cholesterol	☐ Thyroid disease
☐ Diabetes	☐ Kidney disease	☐ Tuberculosis

Please indicate if you have completed any of the following procedures/treatments:

Procedure/ Treatment	Yes	Date Completed
Flu vaccine	☐	
Pneumonia vaccine (Pneumovax®)	☐	
Tetanus vaccine	☐	
Shingles vaccine (Zostavax)	☐	
COVID-19 vaccine	☐	
Colonoscopy	☐	
Prostate cancer screening (men)	☐	
Mammography (women)	☐	
Bone density test (women)	☐	
Pap test / pelvic exam (women)	☐	

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Past Surgical History

Please list your surgical history.

Type of Surgery	Date of Surgery (Year)	Surgeon

Obstetrical/Gynecological History

For women, please indicate your obstetrical and gynecological history below.

History of	Number	History of	Yes	No
Pregnancies		HPV	☐	☐
Miscarriages		Abnormal pap	☐	☐
Abortions		Date of last menstrual period		

What is your current form of birth control? Please check all that apply.

☐ None ☐ Medication ☐ Tubal ligation ☐ Vasectomy ☐ IUD ☐ Condom

Family History

	Health History	Living	If deceased, list cause of death
Father			
Mother			
Siblings			
Children			

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Social History

Occupation: _____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you exercise? ☐ Yes ☐ No

If yes, how many days per week? _____

Are you sexually active? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

If yes, what? ☐ cigarettes ☐ pipe ☐ cigars ☐ e-cigs/vaping ☐ chewing tobacco How many years? _____

Do you usually drink over 2 cups of caffeinated beverages per day?

☐ Yes ☐ No How many do you drink per day? _____

Do you regularly drink alcohol? ☐ Yes ☐ No

If yes, please check the answer(s) that best describe your consumption.

Liquor ☐ 1 oz/day ☐ 2 oz/day ☐ 4 oz/day ☐ 6+ oz/day

Beer ☐ 1 bottle/day ☐ 2 bottles/day ☐ 3+ bottles/day

Wine ☐ 1 glass/day ☐ 2 glasses/day ☐ 3+ glasses/day