PennState Health
Milton S. Hershey Medical Center

ADULT HEALTH ASSESSMENT

Patient's Name: ______________________ Date of Birth: ______________________

Daytime Phone: ______________________ Occupation: ______________________

Cell Phone: ______________________ Email: ______________________

Spouse's Name: ______________________ Spouse's Occupation: ______________________

Daytime Phone: ______________________ Email: ______________________

Emergency Contact Name: ______________________ Emergency Contact Phone: ______________________

Reason for Visit: ______________________

Family Physician: ______________________

Marital Status:
Married _____ Single _____ Widowed: _____ Divorced _____ Separated _____ Living Together _____

Do you have a living will?: __________ If not, would you like information about a living will?: __________

What language do you best understand? ______________________

How do you best learn?:

_____ One on One Instruction
_____ Audio Visual Information
_____ Written Information
_____ Group Instruction
_____ Demonstration/Practice
_____ Other ______________________

Medication List

Current Medications
Please list any medications that you currently take regularly (including non-prescription /over the counter medications, and supplements) and their dosage:

	Medication	Dosage/Strength	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

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MUST HAVE AN OOS LABEL ON THE FRONT SIDE OF THIS FORM
(2-SIDED FORMS MUST HAVE AN OOS LABEL ON BOTH SIDES)

Allergies

Medication Allergies
Please list any medication allergies and reaction:

	Medication/Allergy	Reaction(s)
1.		
2.		
3.		
4.		
5.		
6.		

Other Allergies
Please list any other allergies and reaction:

	Other/Allergy	Reaction(s)
1.		
2.		
3.		
4.		
5.		
6.		

Family Medical History:

Illnesses/Conditions
Has anyone in your family had any of the following:

Family Member	High Blood Pressure	Stroke	Heart Attack	Cancer	Diabetes	Lung Disease	Glaucoma	Alcoholism
Mother								
Father								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								
Brother(s)								
Sisters(s)								
Children								
Other								

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Medical History

Illnesses/Conditions
Do you have or have you ever had any of the following:

Illness/Condition	Yes/No	Year	Surgical Procedures/Hospitalizations	Yes/No	Year
Anemia					
Anxiety					
Asthma					
Arthritis					
Birth Defects:					
Cancer					
Colitis					
Concussion					
Depression/Nervous Breakdown			**Childhood Diseases**	**Yes/No**	**Year**
Diabetes			Chickenpox		
Eczema/Psoriasis			Measles		
Emphysema			German Measles		
Gallbladder Disease			Mumps		
Heart Attack/Heart Disease			Polio		
High Blood Pressure			Other:		
High Cholesterol					
HIV/AIDS					
Kidney Disease			**Sexual History**	**Answer**	
Liver Disease/Hepatitis			Are you sexually active?		
Migraine Headaches			Do you have any sexual function problems?		
Mitral Valve Prolapse/Murmur			What is your sexual preference? *(Heterosexual, Homosexual, Transgender, etc.)*		
Osteoporosis					
Rheumatic Fever					
Seizure Disorder			**Gynecological History (women only)**	**Answer**	
Sexually Transmitted Disease			Are you pregnant?		
Sleep Apnea			Are you breast feeding?		
Stroke			Last menstrual period?		
Thyroid Disorder			How many pregnancies have you had?		
Tuberculosis			Have you ever had a miscarriage?		
Ulcer			Have you ever had an abortion?		
			How many children do you have?		
			At what age did you start having periods?		
Prostate Exam (males only)			Date of your last pap smear:		
			Have you ever had an abnormal pap?		
			Date of your last mammogram:		
Any other disease:			Date of your last bone density:		
			Do you use birth control?		
			If yes, please list type:		

Health Maintenance and Prevention:

Please answer the following:

When was your last influenza vaccine (flu shot)? ____________________

When was your last Tetanus shot? ____________________

If you have had a Pneumovax, please provide the date of your last one: ____________________

If you have had a Zostavax (shingles), please provide the date of your last one: ____________________

If you have had a colonoscopy, please provide the date of your last one: ____________________

Rate your eating habits: Healthy ________ Somewhat Healthy __________ Not Very Healthy ____________

If you exercise, please list how often: ____________________

Do you wear glasses and/or contacts? ____________________

Do you have a hearing problem?" ____________________

Do you wear a hearing aid?: ____________________

Are you currently experiencing a lot of stress in your life?: ____________________

Do you wear dentures?:______________________
If you wear dentures, select the best response below:

Full__________ Partial__________ Upper__________ Lower__________ Both__________

Social History:

Please answer the following:

Are you a cigarette smoker?____

Select the response below that best describes your cigarette use:

- Never smoked cigarettes
- Current every day smoker
- Current some day smoker
- Former Smoker, quit in last 30 days
- Former Smoker, quit within 31 days – 1 year
- Former Smoker, quit more than a year ago
- Smoker, current status unknown

Not counting you, do any other smokers live in your household?________________________________

Do you use other tobacco products?____

Select the response below that best describes your other tobacco use:

- Never used other tobacco products
- Current pipe smoker
- Current Smokeless tobacco user
- Former other tobacco user, quit in the last 30 days
- Former other tobacco user, quit in the last 31 days – 1 year
- Former other tobacco use, quit more than a year ago

Do you drink alcohol?____

Select the response below that best describes your alcohol use?

- Never drink alcohol
- Drink beer
- Drink Liquor
- Drink Wine

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Alcohol Frequency:

Select the response below that best describes your alcohol use frequency?

Never

Binge drinking

Daily

Frequently

History of Abuse

Occasionally

Quit

Rarely

Socially

Weekly

Weekends only

Emotional Assessment:

Have you felt down or depressed over the last 2 weeks? ______________________________

Do you have little interest in doing things?______________________________

Family Demographics:
If you have children, please list age, gender, and date of birth (DOB).

Name (Optional)	Age	Gender	DOB

______________________ ______________________ __________
Name of Person Completing Form Date Time

____
Relationship to Patient

______________________ ______________________ __________
Patient's Signature Date Time