Axelix Health Consulting
"Providing Infection Disease management services"

AHCI AXELIX HEALTH CONSULTING, INC.

Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions better.

Patient Name: _____ **Date of Birth:** _____/_____/_____

Main reason for today's visit: _____ **Height** _____ **Weight** _____

Review of Symptoms: Please check any current symptoms related to today's appointment you have.

******If none of these symptoms apply please check here__ ******

Constitutional
- ☐ Recent fevers
- ☐ Sweats
- ☐ Weight Gain
- ☐ Weight loss
- ☐ Unexplained fatigue
- ☐ Unexplained weakness

Eyes
- ☐ Change in vision

Ears
- ☐ Decreased Hearing
- ☐ Ringing in ears

Cardiovascular
- ☐ Chest pain/discomfort
- ☐ Palpitations
- ☐ Short of breath with exertion

Breast
- ☐ Breast lump
- ☐ Nipple discharge

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Shortness of breath

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Blood or change in bowel movement
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Discharge: penis or vagina
- ☐ Unusual vaginal bleeding
- ☐ Concern with sexual functions

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Recent back pain

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Increased thirst
- ☐ Increased appetite

Skin
- ☐ Rash
- ☐ New or change in mole

Neurological
- ☐ Fainting
- ☐ Headache
- ☐ Memory Loss
- ☐ Fall Risk

Psychiatric
- ☐ Anxiety/stress
- ☐ Sleep problem
- ☐ Depression

Blood/Lymphatic
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Medications: Please provide the office staff with your current medication list if you have one, otherwise list prescription and non-prescription medicines, vitamins, home remedies, birth control, herbs, etc. below.

Medication ***Dose*** ***How many times a day***

_____

_____

_____

_____

_____

_____

Allergies or reactions to Medications:

_____

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Date of your most recent IMMUNIZATIONS:

Hepatitis A _____ Hepatitis B _____ **Influenza (flu shot)** _____ MMR _____ Pneumovax _____

Meningitis _____ Tetanus _____ Varicella (chicken pox) shot or illness _____ Tdap _____

Personal Medical History: Please indicate whether you have had any of the following medical problems.

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol
☐ Asthma/Lung Disease ☐ Diabetes ☐ Thyroid Problem
☐ Kidney Disease ☐ Cancer: (Specify) _____ ☐ Other: (Specify) _____

Surgical History: Please list all prior surgeries with dates.

_____

_____

Family History: Please list the current status of your immediate family members

Family Member	Living or Deceased	Age	Medical Conditions
Father			
Mother			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Siblings			
Spouse			
Children			

Social History

Tobacco Use: Are you a current smoker? ☐ **Yes** ☐ **No** If yes, how many cigarettes per day? __ Number of years? __

Are you interested in quitting? ☐ **Yes** ☐ **No** Other tobacco: ☐ **Pipe** ☐ **Cigar** ☐ **Snuff** ☐ **Chew**

Alcohol Use: Do you drink alcohol? ☐ **Yes** ☐ **No** Number of drinks per week? __

Is alcohol use a concern for you or others? ☐ **Yes** ☐ **No**

Drug Use: Do you use recreational drugs? ☐ **Yes** ☐ **No** Have you ever used needles to inject drugs? ☐ **Yes** ☐ **No**

Sexual Activity: Are you sexual active? ☐ **Yes** ☐ **No** Current sex partner is: ☐ **Male** ☐ **Female**

Birth control method: _____

Have you ever had any sexually transmitted diseases (STDs)? ☐ **Yes** ☐ **No**

Are you interested in being screened for sexually transmitted diseases? ☐ **Yes** ☐ **No**

Other Concerns:

Occupation: _____ Years of education/highest degree: _____

Who lives at home with you? _____

Do you have pets? ☐ **Yes** ☐ **No** Please specify: _____

Have you traveled outside of the country: ☐ **Yes** ☐ **No** If yes, list countries recently visited and dates:

_____

_____