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.			

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								

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

ADULT HEALTH ASSESSMENT

Medical History

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

Illness/Condition	Yes/No		Year
Anemia			
Anxiety			
Asthma			
Arthritis			
Birth Defects:			
Cancer			
Colitis			
Concussion			
Depression/Nervous Breakdown			
Diabetes			
Eczema/Psoriasis			
Emphysema			
Gallbladder Disease			
Heart Attack/Heart Disease			
High Blood Pressure			
High Cholesterol			
HIV/AIDS			
Kidney Disease			
Liver Disease/Hepatitis			
Migraine Headaches			
Mitral Valve Prolapse/Murmur			
Osteoporosis			
Rheumatic Fever			
Seizure Disorder			
Sexually Transmitted Disease			
Sleep Apnea			
Stroke			
Thyroid Disorder			
Tuberculosis			
Ulcer			
Prostate Exam (males only)			
Any other disease:			

Surgical Procedures/Hospitalizations	Yes/No		Year

Childhood Diseases	Yes/No		Year
Chickenpox			
Measles			
German Measles			
Mumps			
Polio			
Other:			

Sexual History	Answer
Are you sexually active?	
Do you have any sexual function problems?	
What is your sexual preference? *(Heterosexual, Homosexual, Transgender, etc.)*	

Gynecological History (women only)	Answer
Are you pregnant?	
Are you breast feeding?	
Last menstrual period?	
How many pregnancies have you had?	
Have you ever had a miscarriage?	
Have you ever had an abortion?	
How many children do you have?	
At what age did you start having periods?	
Date of your last pap smear:	
Have you ever had an abnormal pap?	
Date of your last mammogram:	
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 _____