



This is a 2 sided form – Please complete both sides

Northern Oswego County Health Services, Inc.

Adult Health History Form

Name: _____ Date: _____

DOB: _____ Sex: M F

MEDICAL PROBLEMS: Do you have, or have you had any of the following medical problems? Circle Y for Yes or N for No, if yes please explain below.

Y	N	High Blood Pressure	Y	N	Kidney Disease
Y	N	Heart Disease	Y	N	Liver Disease
Y	N	Diabetes	Y	N	Cancer of any type
Y	N	Thyroid Problems	Y	N	Neurological Disease
Y	N	High Cholesterol	Y	N	Orthopedic Problems
Y	N	Chronic Lung Disease	Y	N	Arthritis
Y	N	Stomach Disorders	Y	N	Infectious Disease/Hepatitis/HIV

List any other serious illnesses/or explain Yes answers:

FAMILY HISTORY: Any family history of any serious illnesses such as diabetes, high blood pressure, heart disease, or cancer:

HOSPITALIZATIONS/SURGERY:

NONE:

DATE:

CONDITION/SURGERY



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SOCIAL HISTORY: Occupation: _____

Number of Adults at Home: _____ Number of Children at Home: _____

Is your home tobacco – and smoke-free? Y / N

Smoke: Y / N How Many Packs Per Day? _____ Age when started?: _____

Caffeine: Y / N Alcohol: Y / N If yes, how much/how often? _____

When was your last comprehensive health examination Date ____/____/____

Note: We recommend a comprehensive evaluation for healthy individuals every three years until age 40, every two years from ages 40 to 50 and annually after the age of 50. Patients with a chronic medical problem should have an annual health evaluation.

If you were born after 1957, have you had a second measles, mumps and rubella vaccination? Y / N

If you are at least 65 years old or have a chronic health problem, have you received the pneumococcal and flu vaccines? Y / N

If you are a female, do you do a monthly self-breast exam? Y / N

When was your last breast exam by your physician? Date: ____/____/____

Date of last mammogram: ____/____/____ Date of last pap smear: ____/____/____

Note: One out of every 10 women will get breast cancer. The best approach is early detection by doing a monthly self-breast exam, an annual breast exam by our physician and periodic mammograms.

Have you ever had colon cancer screening? i.e. colonoscopy ? Y / N