THOMAS CHITTENDEN
HEALTH CENTER

Adult Health History

Patient Name: _____ DOB: _____

To provide you with the most appropriate care, it is important that we know your detailed health history. Please take a few moments to fill out this Health History form, so that we can get to know you. Please note that if you have signed up for our Patient Portal, you can bypass this form and enter the information directly into your electronic health record!

MEDICATIONS – Please bring all medication bottles with you to your first visit

*** Please include prescription and non-prescription medications used on a regular basis (Including aspirin, vitamins, laxatives, birth-control, injections, alternative medicines, etc.) Use extra sheet if needed.

Medication Name	Strength	Frequency	Used for

ALLERGIES / SENSITIVITIES – Please list all reactions. Use extra sheet if needed

Medication/Substance	Reaction	Date

MEDICAL CONDITIONS – Please list all current or pertinent past medical conditions

Condition	Date		Condition	Date

SURGICAL HISTORY

Surgery	Date		Surgery	Date

Family Health History

	Deceased?	Age at death	Diabetes	Heart disease <65yo	Stroke	High blood pressure	Mental illness/mood disorder and type	Cancer (and type)	Other
Father	☐		☐	☐	☐	☐			
Mother	☐		☐	☐	☐	☐			
Paternal Grandfather	☐		☐	☐	☐	☐			
Paternal Grandmother	☐		☐	☐	☐	☐			
Maternal Grandfather	☐		☐	☐	☐	☐			
Maternal Grandmother	☐		☐	☐	☐	☐			
Brother / Sister	☐		☐	☐	☐	☐			
Brother / Sister	☐		☐	☐	☐	☐			
Brother / Sister	☐		☐	☐	☐	☐			
Brother / Sister	☐		☐	☐	☐	☐			
	☐		☐	☐	☐	☐			
	☐		☐	☐	☐	☐			
	☐		☐	☐	☐	☐			
	☐		☐	☐	☐	☐			

PERSONAL HISTORY

Current Marital Status: ◉Single ○Married ○Separated ○Divorced ○Widowed
Current household members (check all that apply): ☐Spouse/significant other ☐Roommate ☐Children ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Grandchildren ☐Other: _____
Do you have smoke alarms in your home: ○ No ○ Yes
Do you have carbon monoxide detectors in your home: ○ No ○ Yes
Is anyone in your home a smoker: ○ No ○ Yes If yes, then who: _____
Do you have any guns in your home: ○ No ○ Yes If yes, are they secured in some way (locked in a gun safe, trigger locks, separate from ammunition), and how: _____

Level of education: ☐High School ☐ Some college ☐ Undergraduate college degree ☐ Some graduate school ☐ Graduate college degree ☐ Trade school
Work status: ○ Full time ○ Part time ○ Self-employed ○ Retired ○ Disabled ○ Not currently employed
Current Occupation: _____ Current Employer: _____
Military history: ○ N/A ○ Yes If yes, explain: _____
Do you follow any specific diet (ie vegetarian, vegan, low carb, etc)? ○ No specific diet plan ○ Yes
Type: _____
Do you feel safe in your current living situation and current relationship? ○ No ○ Yes
Have you ever been a victim of physical or emotional abuse? ○ No ○ Yes

Do you currently use nicotine? ○ No ○ Yes: ☐Smoke ☐ Chew ☐ Vape/E-CIG
How much per day? _____ Age started: _____

Smoked / chewed in past? ○ No ○ Yes: Age started: _____ Age quit: _____
How much alcohol do you drink? ☐ None _____ drinks of _____ per _____
How much marijuana do you use? ☐None I smoke/use/take _____ per _____
Have you used other drugs recreationally? ☐No ☐Current Past (Quit Date): _____
What kind and how much/frequent? _____

Do you exercise regularly? ○ No ○ Yes: Type and frequency: _____
Do you wear a seatbelt in the car? ○ Never ○ Sometimes ○ Always
Do you wear a bike helmet when you ride a bicycle? ○ Never ○ Sometimes ○ Always
Do you currently wear or use (check all that apply): ☐eye glasses for distance ☐eye glasses for reading ☐contact lenses ☐hearing aids ☐dentures (full or partial) ☐cane ☐walker ☐wheel chair ☐orthopedic brace ☐prosthesis ☐other:_____

Sexual History

Sexual activity: ○ Never ○ In the past but not currently ◉ Current
Preferred partners (check all that apply): ☐Male ☐Female ☐Other: _____
How often do you or your partner use condoms? ○ Never ○ Sometimes ○ Always ○ N/A
What do you or your partner use for birth control? ☐N/A _____

OB/GYN History (Women Only)

How many times have you been pregnant in your lifetime? _____
How many times have you given birth? _____
Date of last PAP smear (if applicable): _____
Have you ever had an abnormal PAP? ◯No ◯Yes If yes, please provide details and date: _____
Do you your GYN care from another practice? ◯No ◯Yes If yes, please provide office/provider name:
_____

Advance Directive

Do you have an Advance Directive, Living Will, Health Care Proxy, or some other sort of end-of-life document pertaining to health care decisions? ◯No ◯Yes If yes, please have a copy forwarded to our office to include in your medical record.

Health Maintenance

Test	Date	Results (if known)
Last physical exam		
Dental visit		
Eye visit		
Cholesterol/lipid screening		
Diabetes/sugar screening		
Colon cancer screening (colonoscopy or ColoGuard stool test)		
Mammogram (women >50 yo)		
Bone density screening (over 60 yo)		
Hepatitis C screening (if born 1945-1965)		
Abdominal Aortic Aneurysm (AAA) screening ultrasound (current or previous smokers >65 yo who are male)		
Low-dose lung CT screening (smokers >55 yo who have smoked for more than 30 years, current smokers or quit within the past 15 years)		

Immunization Status

Have you had all of your childhood immunizations? ◯No ◯Yes ◯Unsure

Have you had?	Date (if known)
Tetanus (TDaP, Td, DT)	
Pneumovax/pneumococcal 23 (if over 65 yo)	
Prevnar/pneumococcal 13 (if over 65 yo)	
Shingrix/shingles (if over 50 yo)	
Gardasil/HPV (if under 26 yo)	

Thank you for completing your Health History form!
Please bring this with you on the day of your first appointment.