9820 E Burnside St.
Portland, OR 97216

PEIRSON CENTER FOR CHILDREN

(971) 202-7356
www.peirsoncenter.com

Adult Health History Form

Name_____ Age_____ Date of birth_____

Address:_____City:_____State:_____ Zip:_____

Phone number:_____E-mail:_____

Occupation:_____

Emergency contact:_____ Phone number:_____

Biggest concerns and symptoms to address:

_____

_____

When, where and by who did you last receive medical health care? _____

_____

If you have one, who is your Primary Care Physician?_____

List all drugs, herbs and supplements used here:

Name	Dose	Frequency	Duration

Are you allergic to any medications or other substances? ☐ Y ☐N

Allergy	Type of reaction

Hospitalizations or surgeries?

Reason	Date	Hospital

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Health History

Never	Past	Now		Never	Past	Now	
☐	☐	☐	Hypothyroidism	☐	☐	☐	PCOS
☐	☐	☐	Hyperthyroidism	☐	☐	☐	Depression/Anxiety
☐	☐	☐	Anemia	☐	☐	☐	Sleep Apnea
☐	☐	☐	Constipation	☐	☐	☐	Autoimmune Disease
☐	☐	☐	Cancer_____	☐	☐	☐	Miscarriage (#:_____)
☐	☐	☐	Heart murmur	☐	☐	☐	Irregular periods
☐	☐	☐	Eczema	☐	☐	☐	Headaches

Family History

Never	Past	Now		Never	Past	Now	
☐	☐	☐	Hypothyroidism	☐	☐	☐	Autoimmune disease
☐	☐	☐	Hyperthyroidism	☐	☐	☐	Stroke
☐	☐	☐	Anemia	☐	☐	☐	Osteoporosis
☐	☐	☐	Mental Illness	☐	☐	☐	Birth Defects
☐	☐	☐	Cancer_____	☐	☐	☐	Miscarriage/Infertility
☐	☐	☐	Heart disease	☐	☐	☐	Obesity
☐	☐	☐	High blood pressure	☐	☐	☐	Diabetes

Describe a typical day's diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Cravings:_____

Social History

Do you exercise? ☐ Y ☐N If so, in what form and how often?_____

Do you smoke? ☐cigarettes ☐marijuana ☐neither

Do you drink alcohol? ☐ Y ☐N What form?_____ How much?_____How often?_____

Marital status: ☐Single ☐Married ☐Co-habitate ☐In a relationship