LISSA LUBINSKI MD

816 E 8th Street | Port Angeles, WA 98362
p. 360-406-5220
f. 360-775-2125
connect@lissalubinskimd.com
www.lissalubinskimd.com

Health History for Adults

Name: _____ Date of Birth: _____

What is most important to you in life? What would you do if you didn't have to worry about finances? *(You don't have to necessarily answer this in writing or in person, but I start with this because I believe it's fundamental to who we are and if I never even ask, I may never quite get to the root of some of your health challenges.)* _____
_____

What are your health goals? _____
_____

How would you describe your cultural and ethnic background? _____
_____

How would you describe your gender and sexual orientation? _____

What was your mom's pregnancy with you like? _____
What was your birth like? _____
Were you breastfed or formula fed as a baby? _____
How would you describe your childhood? _____
Did you have a lot of infections as child and/or receive antibiotics many times? Yes / No

What other doctors/healers/providers are involved in your care?

Practitioner	Specialty	Reason for seeing them

Current concerns or problems you would like to address: _____
_____
_____

Health events or problems that have happened to you in the past: _____
_____
_____
_____

Past Surgeries

Surgery	Year and age when it happened	Where it was done

Medication Allergies/Intolerances

Medication	Reaction

Food & Environmental Allergies/Intolerances

Food or Environmental Allergen	Reaction

Current Medications and Supplements (or better yet, bring all of them to your visit!)

Medication or Supplement	Dose (how much and how often)	Reason for taking it

Family History (please include siblings and biological children, may include aunts, uncles, grandparents or any relative with a major medical problem)

Family Member	**Health Problem(s)**
Mother	
Father	
Sibling (please note if brother or sister)	
Maternal grandmother	
Maternal grandfather	
Paternal grandmother	
Paternal grandfather	

Preventive Care Testing

Test	**Have you ever had it? (circle Yes or No)**	**What year was it last done?**	**Was it normal? (circle Yes or No)**
Pap (applies to people with a cervix)	Yes / No / NA		Yes / No / NA
Mammogram (applies to people with breasts)	Yes / No / NA		Yes / No / NA
Colonoscopy	Yes / No		Yes / No
Fasting glucose (sugar)	Yes / No		Yes / No
Cholesterol	Yes / No		Yes / No
HIV	Yes / No		Yes / No
Hepatitis B	Yes / No		Yes / No
Hepatitis C	Yes / No		Yes / No
Gonorrhea/Chlamydia	Yes / No		Yes / No
Bone density testing	Yes / No		Yes / No
PSA (applies to people with a prostate)	Yes / No / NA		Yes / No / NA

Are you interested in being tested for any of these now? _____

Daily Life

Please also fill out additional questionnaire called "Diet, Nutrition and Lifestyle Journal"

Occupation: _____

If you are retired, what did you do before you retired? _____

Who lives at home with you? _____

You have a right to feel safe. Do you have any concerns about your safety? Yes / No

What questions or concerns to you have about food or nutrition? _____

_____

Daily Life Continued

Substance	Do you consume it?	More information
Caffeine	Yes / No	What kind? How many servings per day on average?
Cigarettes	Yes / No	How old were you when you first started smoking? How many packs per day on average? How old were you when you quit (or are you still smoking)? How many times have you tried quitting?
Vaping	Yes / No	How much are you using? How often? How old were you when you started this? Have you ever tried quitting?
Smokeless tobacco	Yes / No	What kind? How old were you when you first started using this? How old were when you quit (or are you still using it)?
Marijuana products	Yes / No	What kind? How often? What does it help you with?
Alcohol	Yes / No	How many drinks in an average week? How often do you have more than 3 drinks in one day? Have you ever felt worried about your alcohol use? Yes / No
Other substances	Yes / No	What other substances have been a part of your life?

Reproductive Health

For people with a uterus

Age when you had your first period: _____

Age when you had your last period (went through menopause): _____

Are or were your periods regular? Yes / No

Are you having any discomfort in your pelvic or vaginal areas? Yes / No

Have you had any vaginal bleeding since menopause? Yes / No

For everyone

Do you have biological children? Yes / No

What are you using for contraception? _____

What concerns or questions do you have about sexual function? _____

_____

Please see next page for pregnancy history if it applies to you.

Thank you again for your time and honesty in filling this out!

Pregnancy History

Skip this section if you've never been pregnant or do not wish to give a pregnancy history at this time. Please list the pregnancies you've experienced, the year they happened, and circle the box(es) that describes the pregnancy best:

Year & your age	Timing of birth (please circle)	Kind of birth (please circle)	Any complications or anything else I should know?
	Early pregnancy loss Termination of pregnancy Preterm (before 37 weeks) Term (close to due date, 37-40 weeks) Postdates (after 40 weeks)	Vaginal birth Birth by cesarean	
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