ADULT MEDICAL HISTORY FORM

Date:____/____/____

Name: ___________________________________Date of Birth:______________SS#:________________
Address:
____
Birth Place:
_________________________City:______________________State:_________Country:_______________
Home Phone:___________________________________Cell Phone:_______________________________
Last Doctor Seen:____

Current Medications:
(Including over the counter, herbs, and vitamins)

Allergies:

____ ___________________________________
____ ___________________________________
____ ___________________________________

Past Medical History:

Do you or have you had any of the following:

_____ Hypertension-High Blood pressure
_____ Renal Disease – kidney Disease
_____ Heart Attack
_____ Congestive Heart Failure
_____ Asthma
_____ Bleeding disorder

_____ High Cholesterol
_____ Diabetes
_____ Palpitations-irregular Heart rhythm
_____ Stroke
_____ GERD- Gastric Acid Reflux
_____ PUD- Stomach Ulcers

_____ Depression/other mental Health problems
_____ Emphysema
_____ Cancer
_____ Seizures
_____ Thyroid Disease
_____ Arthritis

Past Surgical History:

Please list any major or minor surgeries you have had and the approximate date of the surgery.

____
____
____
____
____
____

Review of Systems:

Do you have or have you recently had any of the following:

_____ Fever
_____ Vision Changes
_____ Shortness of Breath
_____ Chest Pain
_____ Heartburn
_____ Changes in Bowel Habits
_____ Nausea/Vomiting
_____ Depressed Mood

_____ Memory Problems
_____ Joint Pain/Swelling
_____ Sweating/Night Sweats
_____ Anxiety
_____ Polyuria- Frequent Urination
_____ Polydipsia- Increased Thirst
_____ Tremor

_____ Dysphasia- Trouble Speaking
_____ Dysuria- Painful Urination
_____ Back Pain
_____ Weight Loss
_____ Changes in Hearing
_____ Cough
_____ Palpitations- Irregular Heart Beat

Family History:

Does anyone in your family (parents, brothers/sisters, or children) have any of the following:

_____ Alcoholism
_____ Asthma
_____ Bleeding Disorder
_____ Cancer
_____ Renal Disease- Kidney Disease
_____ Epilepsy/Seizures
_____ Heart Disease
_____ Hypertension- High Blood Pressure
_____ Diabetes
_____ Migraine Headaches
_____ Osteoporosis
_____ Stroke
_____ Thyroid Disease
_____ Mental Illness

Social History:

What is the last grade you completed in school? __________________________ Are you a college graduate? ________________
Are you employed?_____If yes, what kind of work do you do?____
Do you drink alcohol?_____If yes, what do you drink (beer, wine, liquor) and how often?__________________________________
Do you use tobacco?_____ If yes, what do you use (cigarettes, chewing tobacco, snuff) and how often?_____________________
How many years have you used tobacco?________________ Have you ever tried to quit?__________________________________
Do you use or have you ever used "street drugs"?______If yes, what kind and for how long?______________________________
Have you ever tried to quit?_________________Have you ever been treated for a drug problem? ___________________________
Are you sexually active? If yes, do you use condoms or other means of preventing sexually transmitted diseases?______________
____
Do you exercise? If yes, what type of exercise do you do and how often? ____
If no, what prevents you from exercising? ____
Do you always wear a seat belt? ____
Do you have smoke detectors in your home?____
Do you have a living will/advance directive?____
____

Prevention/Screening:

Have you ever been screened for colon cancer?_________ If yes, when and what test was done?_____________________________
When was your last dental appointment? ____
Have you ever had a *severe* sunburn? ____
When was your last eye exam? ____
Have you ever had a pneumovax? If yes, when? ____
Have you ever had a flu vaccine? If yes, when? ____

For Women Only:

How old were you when you started your period? ____
Are you still having a regular period? If no, how old were you when it stopped?____
When was your last pap smear?____________________________Your last mammogram? _____________________________
Have you ever had an abnormal pap smear? If yes, when and what type of treatment did you have?__________________________
____

For Men Only:

When was your last prostate exam? Last PSA? ____
Have you ever had an abnormal PSA? If yes, when and what type of treatment did you have? ______________________________
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