

**ADULT MEDICAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

What is your chief concern today? \_\_\_\_\_

**MEDICATIONS:** List all prescription and over the counter medications that you are currently taking regularly. Include vitamin, herbs and other supplements. \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<p><b>ALLERGIES:</b> Medications you are allergic to or have reactions to:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List any non-medication allergies:</p>	<p><b>IMMUNIZATIONS:</b> Please list dates of last shot</p> <p>Tetanus _____</p> <p>Pneumonia _____</p> <p>Shingles _____</p> <p>Hepatitis B _____ Hepatitis A _____</p>
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**RISK FACTORS:**

Do you smoke?  Current  Quit  Never If quit, when \_\_\_\_\_ Passive smoke exposure:  Yes  No

Do you use any illegal drugs?  Yes  No If yes, please list \_\_\_\_\_

Are you sexually active?  Yes  No If yes, have you had more than 5 partners?  Yes  No

Do you have sex with:  Men  Women  Both

How many caffeinated drinks do you have each day? \_\_\_\_\_

Do you have a family history of heart attacks at a younger age? Female < 65:  Yes  No Male < 55:  Yes  No

Do you drink alcohol?  Yes  No If yes, type of alcohol: \_\_\_\_\_ Drinks per day: \_\_\_\_\_

Exercise:  Yes  No Times per week: \_\_\_\_\_ Type of exercise: \_\_\_\_\_

Seatbelt use: 100% 75% 50% 25% 0%

Sun exposure:  Frequently  Occasionally  Rarely  Remote

Are you, or were you exposed to hazards at your job (dust, fumes, noise)?  Yes  No Please list: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:** Circle if you've had

<p>Anemia</p> <p>Arthritis or Rheumatism</p> <p>Asthma</p> <p>Bladder Infections</p> <p>Blood Clots</p> <p>Broken Bones</p> <p>Cancer Type: _____</p> <p>Colitis Or Other Bowel Disease</p> <p>Depression</p> <p>Diabetes</p> <p>Drug Or Alcohol Problems</p>	<p>Eczema</p> <p>Gallbladder Disease</p> <p>Hay fever</p> <p>Head Injuries</p> <p>Heart Disease</p> <p>High Blood Pressure</p> <p>High Cholesterol</p> <p>Hives</p> <p>Jaundice</p> <p>Liver Disease</p> <p>Joint Dislocations</p> <p>Kidney Disease</p>	<p>Meningitis</p> <p>Mental Disorder</p> <p>Migraine Headaches</p> <p>Pneumonia</p> <p>Polio</p> <p>Rheumatic Fever</p> <p>Sciatica</p> <p>Seizure Or Epilepsy</p> <p>Sexually Transmitted Diseases</p> <p>Stomach Ulcer or Reflux</p> <p>Stroke</p> <p>Thyroid Problems</p>
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**SURGERIES:** Check if you have had:  Tonsillectomy  Appendectomy  Gallbladder  Hysterectomy

List any other surgeries:

Type \_\_\_\_\_ Year \_\_\_\_\_  
 Type \_\_\_\_\_ Year \_\_\_\_\_  
 Type \_\_\_\_\_ Year \_\_\_\_\_  
 Type \_\_\_\_\_ Year \_\_\_\_\_

Type \_\_\_\_\_ Year \_\_\_\_\_  
 Type \_\_\_\_\_ Year \_\_\_\_\_  
 Type \_\_\_\_\_ Year \_\_\_\_\_  
 Type \_\_\_\_\_ Year \_\_\_\_\_

**HOSPITALIZATIONS** (Other than for surgery) Please list:

Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Date \_\_\_\_\_ Reason \_\_\_\_\_

**TESTS / EXAMS:** Check and indicate year

Physical exam Year \_\_\_\_\_  Eye Exam Year \_\_\_\_\_  PSA (prostate cancer blood test) Year \_\_\_\_\_  
 Cholesterol test Year \_\_\_\_\_  Blood Sugar test Year \_\_\_\_\_  Vitamin D test Year \_\_\_\_\_  
 Last colon cancer screening:  Colonoscopy Year \_\_\_\_\_  Other (list) \_\_\_\_\_ Year \_\_\_\_\_

**FOR WOMEN ONLY**

Date of last period: \_\_\_\_\_ Date of last pap: \_\_\_\_\_  Normal  Abnormal  
 Date of last mammogram: \_\_\_\_\_  Normal  Abnormal  
 Number of pregnancies: \_\_\_\_\_ Live births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Living children: \_\_\_\_\_  
 How much milk do you drink? \_\_\_\_\_ Do you take calcium?  YES  NO  
 Do you perform monthly self-breast exam  YES  NO  
 Do you, or have you ever had the following?  
 Abnormal PAP  Abnormal mammogram  Breast cancer  Cervical cancer

Is there anything else about your medical history that you would like your doctor to know? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list other healthcare providers you are receiving care from (indicate name & reason): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY:**

RELATIONSHIP	NAME	BIRTH YEAR (if living)	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers & Sisters				
Children				

If there is a family history of any of the following, circle the relationship of any that applies:

	RELATIONSHIP			
Alcohol or other substance abuse	Mother	Father	Sibling	Child
Asthma	Mother	Father	Sibling	Child
Breast Cancer	Mother	Father	Sibling	Child
Heart Disease	Mother	Father	Sibling	Child
Colon Cancer	Mother	Father	Sibling	Child
Stroke	Mother	Father	Sibling	Child
Deafness	Mother	Father	Sibling	Child
Depression/Suicide/Mental illness	Mother	Father	Sibling	Child
Diabetes	Mother	Father	Sibling	Child
Epilepsy/Seizures	Mother	Father	Sibling	Child
Hepatitis (type _____)	Mother	Father	Sibling	Child
High blood pressure	Mother	Father	Sibling	Child
High Cholesterol	Mother	Father	Sibling	Child
Osteoporosis	Mother	Father	Sibling	Child
Ovarian Cancer	Mother	Father	Sibling	Child
Prostate Cancer	Mother	Father	Sibling	Child
Tuberculosis	Mother	Father	Sibling	Child

Other significant family history: \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Previous occupations: \_\_\_\_\_ School year completed: \_\_\_\_\_

Are you adopted?  Yes  No

Marital status:  Single  Married  Divorced  Separated  Other \_\_\_\_\_

Spouse/Partner occupation \_\_\_\_\_

Names and dates of birth of persons *in your household*, and their relationship to you: \_\_\_\_\_

Life changes (new job, retired, birth, divorce, death in family) in the past 12 months: \_\_\_\_\_

Do you have any religious practices that would affect how we medically care for you?  YES  NO

Do you have any of the following?

Healthcare Directive (Living Will)  Yes  No Durable Power of Attorney for healthcare  Yes  No

POLST  Yes  No Other Advance Directive  Yes  No

Would you like more information on the above documents?  Yes  No

**REVIEW OF SYSTEMS:** Circle any/all of the following symptoms that you are **CURRENTLY** concerned about:

GENERAL HEALTH

- No complaints
- Fever
- Chills
- Sweats
- Loss of appetite
- Fatigue
- Weakness
- Don't feel well
- Weight change
- Wake up tired
- Day fatigue/sleepy
- Snoring
- Sleep problems

EYE

- No complaints
- Blurring
- Double vision
- Irritation/Itching
- Redness
- Discharge
- Vision loss
- Eye pain
- Light hurts eyes

EAR/NOSE/THROAT

- No complaints
- Earache
- Ear discharge
- Ear ringing/buzzing
- Decreased hearing
- Nasal congestion
- Nasal discharge
- Postnasal drip
- Nosebleeds
- Sore throat
- Hoarseness
- Itching nose/eyes
- Sneezing

CARDIOVASCULAR

- No complaints
- Chest discomfort
- Pounding/racing heart
- Lightheadedness
- Passing out/fainting
- Shortness of breath with activity
- Shortness of breath lying down
- Sudden waking with shortness of breath
- Swelling in feet/ankles
- Leg pain with exercise

RESPIRATORY

- No complaints
- Coughing
- Wheezing
- Shortness of breath at rest
- Coughing up phlegm
- Coughing up blood
- Painful breathing

GASTROINTESTINAL

- No complaints
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Dark black stools
- Red blood in stools
- Gas/bloating
- Indigestion/heartburn
- Swallowing problems
- Painful swallowing
- Jaundice

GENITAL/URINARY

- No complaints
- Painful urination
- Blood in the urine
- Frequency
- Get up to urinate at night
- Incontinence
- Genital sores
- Less interested in sex
- Males:
  - Penis discharge
  - Erectile dysfunction
  - Urinating more often
  - Hard to start urine flow
  - Decreased stream
- Females:
  - Urgency
  - Hesitancy
  - Vaginal Discharge
  - Missed periods
  - Abnormally Heavy Periods
  - Abnormal Vaginal Bleeding
  - Pelvic Pain
  - Painful Intercourse

MUSCULOSKELETAL

- No complaints
- Neck pain
- Upper back pain
- Lower back pain
- Joint pain
- Joint swelling
- Joint stiffness
- Muscle cramps
- Muscle weakness
- Pain radiating down leg
- Restless legs

DERMATOLOGY

- No complaints
- Rash
- Itching
- Dryness
- Changing lesions
- Non-healing sores

NEUROLOGY

- No complaints
- Weakness of a limb
- Numbness/tingling in arms/legs
- Seizures
- Tremors
- Dizziness
- Loss of vision
- Balance problems
- Frequent falls
- Frequent headaches
- Severe headaches
- Difficulty speaking
- Difficulty swallowing
- Clumsiness
- Confusion
- Memory loss

PSYCHIATRIC

- No complaints
- Feel down, depressed
- Feel overwhelmed
- Lack joy in my life
- Little interest/pleasure in doing things
- Anxious or worried
- Excessive sleep
- Inadequate sleep
- Change in appetite
- Difficult to concentrate
- Thoughts of suicide
- Hallucinations
- Fears

ENDOCRINE

- No complaints
- Get cold easily
- Overheat easily
- Drinking more fluids than usual
- Eating more than usual
- Urinating more than usual
- Unintended weight change

HEMATOLOGY

- No complaints
- Abnormal bruising
- Bleeding problems
- Bleeding gums
- Frequent nosebleeds
- Enlarged lymph nodes

ALLERGY IMMUNOLOGY

- No complaints
- Hives
- Allergic Rash
- Allergy Symptoms
- Seasonal Allergies
- Food Intolerances
- Animal Intolerances
- Recurring/Frequent Infections

BREAST

- No complaints
- Breast lump L or R
- Breast pain
- Breast tenderness
- Breast redness
- Nipple discharge
- Bloody nipple discharge
- Breast enlargement

ANY OTHER HEALTH CONCERNS:

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