

ADULT MEDICAL HISTORY FORM

NAME _____ **DOB** _____ **DATE** _____

Person filling out form, if different from above _____

ALLERGIES _____

Occupation: _____

Single Married Separated Divorced Widowed

PAST MEDICAL HISTORY/ FAMILY HISTORY- Please circle Y for any medical problems you have had and F for any medical problems family members (Parents, Grandparents, Aunts, Uncles, Brothers, Sisters) have had:

Y F Arthritis	Y F Epilepsy	Y F High Blood Pressure	Y F Polio
Y F Asthma	Y F Gallstones	Y F Kidney Problems	Y F Rheumatic Fever
Y F Blood Disease	Y F German Measles	Y F Liver Disease	Y F Rheumatism
Y F Breast Lumps	Y F Glaucoma	Y F Lung Problems	Y F Sinusitis
Y F Bronchitis	Y F Gout	Y F Major Injury	Y F Thyroid Disease
Y F Cancer/ Tumor	Y F Heart Problems	Y F Measles	Y F Tuberculosis
Y F Depression	Y F Hemorrhoids	Y F Mental Problems	Y F Ulcers
Y F Diabetes	Y F Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Y F Migraines	Y F Urinary Tract Infection
Y F Emphysema / COPD	Y F Hernias	Y F Pancreatitis	Y F Venereal Disease

OTHER HISTORY

PAST HOSPITALIZATIONS/ SURGERIES (inc. year)

SOCIAL HISTORY	No	Yes	Qty Daily	Past History
Alcohol				
Tobacco				
Coffee/Tea/Caffeine				
Exercise				
Street Drugs				

FOR ALL PATIENTS: Dates of most recent known exams/tests/immunizations:

Complete Physical Exam	Tetanus Vaccine	w/ Pertussis (Tdap)
Blood Sugar (Glucose) Test	Flu Vaccine	
Stool Checked for Blood	Pneumonia Vaccine	
Flexible Sigmoidoscopy/Procto/Colonoscopy	Hepatitis B Vaccine	
Chest X-Ray	Herpes Zoster Vaccine	
EKG	Meningococcal Vaccine	
Cholesterol Check	TB Skin Test	

PREVENTION MEASURES:

Do you perform skin self exams? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you eat a well balanced diet? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you take vitamins? <input type="checkbox"/> Y <input type="checkbox"/> N	Calcium? <input type="checkbox"/> Y <input type="checkbox"/> N Folic Acid? <input type="checkbox"/> Y <input type="checkbox"/> N
Do you have emotional problems/concerns? <input type="checkbox"/> N <input type="checkbox"/> Y	Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Other
Have you been abused? <input type="checkbox"/> N <input type="checkbox"/> Y	Physically <input type="checkbox"/> Emotionally <input type="checkbox"/> Sexually
Have you been exposed to: <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> TB <input type="checkbox"/> Hepatitis <input type="checkbox"/> Other	
Have you traveled outside the USA in the past year? <input type="checkbox"/> N <input type="checkbox"/> Y	Where?
Are you sexually active? <input type="checkbox"/> Y <input type="checkbox"/> N	
With whom do you prefer to have sex? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both	Do you use condoms? <input type="checkbox"/> Y <input type="checkbox"/> N
When was your last dental exam?	When was your last eye exam?
Do you perform breast self-exams (women)? <input type="checkbox"/> Y <input type="checkbox"/> N	Do you perform testicle self-exams (men)? <input type="checkbox"/> Y <input type="checkbox"/> N

FOR WOMEN ONLY: Past OB/GYN History:

Age at first period	Number of times pregnant
Age of stopping periods	Number of miscarriages
First day of last period (if still having periods)	Have you ever used contraceptive pills?
Length of time between periods	What type of contraception do you currently use?
How long do your periods last?	Have you ever had an abnormal Pap smear?
When was your last mammogram?	Date of last pelvic exam/pap smear

