Name   Date

Adult Medical History Form

Your answers on this form will help your provider better understand your medical concerns and conditions better. This form will NOT be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

AGE ________ How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: ________________________________

Other concerns I would like to discuss if there is time: ________________________________

REVIEW OF SYMPTOMS: Please check any CURRENT symptoms you have.

Constitutional
____ Fevers/sweats/weakness
____ Unexplained weight loss/gain

Eyes ____ Change in vision

Ears/Nose/Throat/Mouth
____ Difficulty hearing/ringing in ears
____ Hay fever/allergies

Cardiovascular
____ Chest pain/discomfort
____ Palpitations

Breast ____ Breast lump/nipple discharge

Respiratory ____ Cough/wheeze

Gastrointestinal
____ Blood in bowel movement
____ Nausea/vomiting/diarrhea

Genitourinary
____ Nighttime urination
____ Leaking urine
____ Unusual vaginal bleeding
____ Discharge: penis or vagina

Musculoskeletal ____ Muscle/joint pain

Skin ____ Rash/new or change in mole

Neurological
____ Headaches
____ Memory loss

Psychiatric
____ Anxiety/stress
____ Sleep problem
____ Depression

Blood/Lymphatic ____ Unexplained lumps
____ Easy bruising/bleeding

Other ____ Concern with sexual function

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ☐ Yes ☐ No

Medications: Please Complete Med List Form

ALLERGIES or REACTIONS TO MEDICINES: ________________________________

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A ______ Hepatitis B ______ Influenza (flu shot) ______ Measles ______ Pneumovax (pneumonia) ______

Rubella ______ Tetanus (Td) ______ Varicella (chicken pox) shot or Illness ______

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) ____________ Date ____________ Abnormal? ☐ Yes ☐ No

Sigmoidoscopy ______ or Colonoscopy ______ Date ____________ Abnormal? ☐ Yes ☐ No

Women: Mammogram ______ Date ______ Abnormal? ☐ Yes ☐ No Pap Smear ______ Date ______ Abnormal? ☐Yes ☐No

Men: PSA (prostate) ____________ Date ____________ Abnormal? ☐ Yes ☐ No

PLEASE TURN OVER

FORM 143952 (July 2005)

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

____ Heart disease: *specify type* ______________

____ Heart attack (412)

____ High blood pressure

____ Diabetes

____ Other: (specify): ______________

____ High cholesterol

____ Thyroid problem

SURGICAL HISTORY: Please list all prior operations (with dates).

____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism ______________

Cancer, specify type ______________

Heart Attack ______________

Depression/Suicide ______________

Diabetes ______________

High Cholesterol ______________

High Blood Pressure ______________

Stroke ______________

Other: ______________

Other: ______________

SOCIAL HISTORY

Tobacco Use

Cigarettes ❑ Never ❑ Quit Date ______________

❑ Current Smoker: packs/day ________ # of yrs ________

Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew

Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use

Do you drink alcohol? ❑ No ❑ Yes # drinks/week ________

Is your alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use

Do you use any recreational drugs? ❑ No ❑ Yes

Have you ever used needles to inject drugs? ❑ No ❑ Yes

Sexual Activity

Sexually active: ❑ Yes ❑ No ❑ Not currently

Current sex partner(s) is/are: ❑ male ❑ female

Birth control method: ______________ ❑None needed

Have you ever had any sexually transmitted diseases (STDs)? ❑ No ❑ Yes

Are you interested in being screened for sexually transmitted diseases? ❑ No ❑ Yes

Other Concerns

CAFFEINE Intake: ❑ None ❑ Coffee/tea/soda _____ cups/day

WEIGHT: Are you satisfied with your weight? ❑ No ❑ Yes

DIET: How do you rate your diet? ❑ Good ❑ Fair ❑ Poor

Do you eat or drink 4 servings of dairy or soy daily or take calcium supplements? ❑ No ❑ Yes

EXERCISE: Do you exercise regularly? ❑ No ❑ Yes

What kind of exercise? ______________

How long (minutes) ________ How often? ________

If you do not exercise, why? ______________

SAFETY: Do you use a bike helmet? ❑ No ❑ Yes ❑ NA

Do you use seatbelts consistently? ❑ No ❑ Yes

Is VIOLENCE at home a concern for you? ❑ No ❑ Yes

Have you ever been ABUSED? ❑ No ❑ Yes

Do you have a GUN in your home? ❑ No ❑ Yes

SOCIOECONOMICS Occupation: ______________ Employer: ______________

Years of education/highest degree: ______ Marital Status: Single Partner/Married Divorced Widowed Other: ______________

Spouse/partner's name: ______________ Number of children/ages: ______________

Who lives at home with you? ______________

WOMEN'S HEALTH HISTORY: # pregnancies ________ # deliveries ________ # abortions ________ # miscarriages ________

1st day of most recent period: ______________