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