



6618 Sitio del Rio B-101 Austin, Texas 78730 Phone: 512.524.2336 Fax: 512.372.8525

ADULT MEDICAL HISTORY FORM

Name: _____ Sex: M F Date of Birth: _____ Age: _____
Last First Middle

I. PAST MEDICAL HISTORY

	Yes	No		Yes	No	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or Glandular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma & Lung	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver, Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Back/Spine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury, Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Colon Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____

II. PAST SURGICAL HISTORY

	Yes	No		Yes	No	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
Ear Tubes	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy (uterus)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	Ovaries removed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroidectomy	<input type="checkbox"/>	<input type="checkbox"/>	Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Knee Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>	Hip Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

III. MEDICATIONS

Regular Medications (include vitamins, over the counter, birth control, herbal meds)

(Example: Crestor, 10 mg, 1 a day)

Drug	Drug Strength	Frequency	Drug	Drug Strength	Frequency
1 _____			6 _____		
2 _____			7 _____		
3 _____			8 _____		
4 _____			9 _____		
5 _____			10 _____		

ALLERGIES TO MEDICATIONS / OTHER: _____

Immunizations: Hepatitis A _____ Hepatitis B _____ MMR _____ Varicella _____ IPV _____
 Dtap/Td/Tdap _____ Pneumovax-23 _____ Gardasil _____ Zostavax _____ PPD _____

GYN (Women only) Age menses began _____ Last menstrual period _____ Pregnancies _____
 Full Term _____ Premature _____ Still Born _____ Abortion/Miscarry _____ Living children _____

IV. SOCIAL HISTORY

Marital Status: Married Single Divorced Widowed
 Do you use tobacco? Yes No Type? _____ How much per day? _____ For how long? _____
 Are you interested in quitting? _____
 Alcohol Yes No How many drinks / week? _____
 Caffeine Yes No How many drinks / day of: coffee tea soda
 Currently sexually active? Yes No New partner in the last year? Yes No
 Highest level of education? _____
 Occupation? _____
 Exposure to toxic chemical, work related injuries or stresses? _____
 Military Service? _____
 Foreign Travel (Where?) _____
 Do you wear seat belts? Always Sometimes Never
 Exercise Schedule? _____
 Major changes, stresses in: Family 1 2 3 4 5 Finances 1 2 3 4 5 Work 1 2 3 4 5
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V. FAMILY HISTORY

	Age	IF LIVING Health	Age	IF DECEASED Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers/ Sisters	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Do you have a family history of: (Circle any that apply and explain below, include blood relatives only)

- | | | | |
|--------------------|----------------|--------------------|----------------------|
| Diabetes | Cancer | Heart Disease | High Blood Pressure |
| Peptic Ulcer | Stroke | Heritable Disorder | Rheumatoid Arthritis |
| Epilepsy | Gout | Tuberculosis | Glaucoma |
| Alcohol/Drug Abuse | Kidney Disease | Migraines | Asthma/Lung Disease |
| Colon Disease | Blood Disease | Mental Illness | Sickle Cell Anemia |

Please indicate which family member (include maternal or paternal) is/was affected and any details:

The above is complete and true to the best of my knowledge. I, the undersigned, voluntarily consent and grant permission to the physician to perform tests, treatments and procedures as indicated for myself or the above named minor for as long as I am a patient of the physician.

 Patient's Signature Date Reviewed by Date