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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	❑	❑	Diabetes	❑	❑	Other: _____
Kidney Disease	❑	❑	Thyroid or Glandular	❑	❑	_____
Asthma & Lung	❑	❑	Cancer	❑	❑	_____
Liver, Hepatitis	❑	❑	Back/Spine Disorder	❑	❑	_____
Gastrointestinal	❑	❑	Rheumatic Fever	❑	❑	_____
Peptic Ulcer	❑	❑	Stroke	❑	❑	_____
Head Injury, Seizures	❑	❑	Migraines	❑	❑	_____
Psychiatric Disorder	❑	❑	Colon Disorder	❑	❑	_____
High Blood Pressure	❑	❑	HIV or AIDS	❑	❑	_____

II. PAST SURGICAL HISTORY

	Yes	No		Yes	No	
Cataract	❑	❑	Hernia	❑	❑	Other: _____
Ear Tubes	❑	❑	Hysterectomy (uterus)	❑	❑	_____
Tonsillectomy	❑	❑	Ovaries removed	❑	❑	_____
Thyroidectomy	❑	❑	Tubal ligation	❑	❑	_____
Breast Surgery	❑	❑	Vasectomy	❑	❑	_____
Heart Surgery	❑	❑	Knee Surgery	❑	❑	_____
Gallbladder	❑	❑	Hip Surgery	❑	❑	_____
Appendix	☐	☐	Prostate	☐	☐	_____

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: _____

Date of Last: Mammogram_____ Colonoscopy_____
Pneumonia Vaccine_____ Shingles Vaccine_____

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

Are Immunizations up to date? YES ☐ NO ☐ *Pediatric Patients Must Provide a Copy

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 (L ⟶ H) Finances 1 2 3 4 5 (L ⟶ H) Work 1 2 3 4 5 (L ⟶ H)

V. FAMILY HISTORY

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

Do you have a family history of: (Check M for Maternal and P for Paternal and explain below, include blood relatives only)

	M	F		M	F		M	F		M	F
Diabetes	☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	High Blood Pressure	☐	☐
Peptic Ulcer	☐	☐	Stroke	☐	☐	Heritable Disorder	☐	☐	Rheumatoid Arthritis	☐	☐
Epilepsy	☐	☐	Gout	☐	☐	Tuberculosis	☐	☐	Glaucoma	☐	☐
Migraines	☐	☐	Kidney Disease	☐	☐	Alchohol/Drug Abuse	☐	☐	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