

MEDICAL HISTORY: ADULT

Name: _____

Date: _____

Past Medical History and Current Concerns

Recurrent illness?

Past Surgical History Please include procedures and year performed.

Procedure	Year	Procedure	Year	Procedure	Year
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medications Please include any prescription medications, herbal medications, and supplements or vitamins. Also indicate dosage and how often taken (eg, daily, twice a day)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies Please include any medicinal, food or environmental allergies. No known drug allergies

Immunizations

When was your last Tetanus shot? _____ or **UNKNOWN**

Have you had any other immunizations like Hepatitis A, Hepatitis B (series of 3 shots), Shingles, Pneumonia? **YES or NO**

If yes, what year? _____

Social History

Do you smoke? **YES or NO** If yes, how many packs per day? _____ If you quit, when and after how many years of smoking? _____

Do you drink alcohol? **YES or NO** If yes, how many drinks per week? _____

Number of caffeinated beverages daily: _____

Any current or previous drug use? **YES or NO** If yes, what substance(s)? _____

Occupation: _____

Please circle: *Single Married Partnered Divorced*

Household occupants (number and relationship): _____

Please circle: *Heterosexual Homosexual Bisexual* Number of lifetime sexual partners: _____

History of sexually transmitted diseases? **YES or NO** Please circle: *Herpes Chlamydia Gonorrhea HPV Syphilis*

Do you have any children? **YES or NO** Names and ages: _____

Regular exercise: **YES or NO** What activity and how often? _____

Any pets? **YES or NO** Kind of pet(s): _____

Have you been a victim of abuse? **YES or NO** Any firearms in the home? **YES or NO** Smoke detectors in the home? **YES or NO**

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Preventative Health

Colonoscopy date and how many years until repeat needed? _____

Last Pap smear and any previous abnormal? _____ Last mammogram? _____

Last cholesterol test and results? _____

Last eye exam? _____

Last HIV test? _____

Family History

	No	Yes	Unsure	Age at Onset	Relationship (AND indicate maternal or paternal side)
Heart disease (e.g. heart attacks, congestive heart failure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Abnormal heart rhythm (e.g. atrial fibrillation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Unexplained death before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer (please name other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
COPD/emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Arthritis (RA or older age)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hypothyroidism (underactive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hyperthyroidism (overactive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Alcoholism/Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Death by Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		