Agave Family
Physicians, PLLC

Adult Medical History

Patient Name : _____ Date Of Birth : _____

YOUR MEDICAL HISTORY : (Check all that apply)

☐ Abnormal Heart Rhythm	☐ Heart Failure	☐ Obesity
☐ Allergies	☐ Heart Murmur	☐ Seizure Disorder
☐ Anemia	☐ Heartburn	☐ Skin Disorder
☐ Arthritis	☐ Hepatitis	☐ Stroke
☐ Asthma	☐ High Blood Pressure	☐ Thyroid Disorder
☐ Cancer	☐ High Cholesterol	☐ Stomach Ulcer
☐ Depression	☐ HIV	☐ _____
☐ Diabetes-Type_____	☐ Kidney Disease	☐ _____
☐ Gout	☐ Lung Disease	☐ _____
☐ Heart Attack	☐ Mental Illness_____	☐ _____

MEDICATIONS :

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

MEDICATION ALLERGIES: LIST DRUG AND REACTION ☐ no medication allergies

_____

PAST SURGICAL HISTORY / HOSPITILIZATIONS: (Check all that apply and list date)

☐ Appendectomy _____	☐ Hysterectomy _____	☐ Ovaries Removed _____
☐ Gallbladder Removal _____	☐ Joint Replacement _____	☐ Other _____
☐ Other _____	☐ Other _____	☐ Other _____

FAMILY HISTORY:

Mother	☐ alive (age ____)	☐ deceased (age____)	Conditions _____
Father	☐ alive (age ____)	☐ deceased (age____)	Conditions _____
Sister	☐ alive (age ____)	☐ deceased (age____)	Conditions _____
Brother	☐ alive (age ____)	☐ deceased (age____)	Conditions _____
_____	☐ alive (age ____)	☐ deceased (age____)	Conditions _____
_____	☐ alive (age ____)	☐ deceased (age____)	Conditions _____

SOCIAL HISTORY:

Do you drink alcohol? ☐ no ☐ yes (type _____; drinks per day_____; drinks per week _____)
Do you smoke tobacco? ☐ no ☐ yes (age started _____; packs per day _____; age quit _____)
Do you drink caffeine? ☐ no ☐ yes (type _____; drinks per day_____)
Do you regularly wear a seatbelt / wear a helmet? ☐ no ☐ yes
Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated ☐ other
With whom do you live? ☐ self ☐ spouse ☐ children (ages/gender_____ _____)
Do you exercise? ☐ no ☐ yes (type _____; times per week_____)

HEALTH MAINTENANCE: (List date and document any abnormalities)

Influenza _____	Pap Smear _____	Normal? ☐ yes	☐ no	_____
Pneumovax _____	Mammogram _____	Normal? ☐ yes	☐ no	_____
Tetanus _____	Bone Density _____	Normal? ☐ yes	☐ no	_____
Eye Exam _____	Colonoscopy _____	Normal? ☐ yes	☐ no	_____
Dental Exam _____	Prostate Exam _____	Normal? ☐ yes	☐ no	_____

Signature: _____ Date : _____