



## Adult Medical History

Patient Name : \_\_\_\_\_ Date Of Birth : \_\_\_\_\_

**YOUR MEDICAL HISTORY : (Check all that apply)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> Heart Failure        | <input type="checkbox"/> Obesity          |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Skin Disorder    |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Stomach Ulcer    |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> HIV                  | <input type="checkbox"/> _____            |
| <input type="checkbox"/> Diabetes-Type _____   | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> _____            |
| <input type="checkbox"/> Gout                  | <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> _____            |
| <input type="checkbox"/> Heart Attack          | <input type="checkbox"/> Mental Illness _____ | <input type="checkbox"/> _____            |

**MEDICATIONS :**

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**MEDICATION ALLERGIES: LIST DRUG AND REACTION**

no medication allergies

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Appendectomy _____        | <input type="checkbox"/> Hysterectomy _____      | <input type="checkbox"/> Ovaries Removed _____ |
| <input type="checkbox"/> Gallbladder Removal _____ | <input type="checkbox"/> Joint Replacement _____ | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Other _____               | <input type="checkbox"/> Other _____             | <input type="checkbox"/> Other _____           |

**FAMILY HISTORY:**

- |         |  |   |                  |
|---------|--|---|------------------|
| Mother  | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| Father  | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| Sister  | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| Brother | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| _____   | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| _____   | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |
| Pneumovax _____   | Mammogram _____     | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |
| Tetanus _____     | Bone Density _____  | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |
| Eye Exam _____    | Colonoscopy _____   | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |
| Dental Exam _____ | Prostate Exam _____ | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |

Signature: \_\_\_\_\_ Date : \_\_\_\_\_