



PATIENT MEDICAL HISTORY ADULT

DATE _____

1.) SOCIAL HISTORY

Name _____ Birthdate _____ / ____ / ____
(Last) (First) (M.I.) (Month) (Day) (Year)

Occupation _____ Education (# of Years Completed) _____

Marital Status _____ Spouse's Name _____ Religion _____

Special cultural beliefs that might affect your healthcare _____

Do you have a Power of Attorney for Healthcare? Yes No Do you have a living will? Yes No

Use of home health or other community services? Yes No

Name of Health Care Providers _____

2.) PAST MEDICAL HISTORY Have you ever had (if so, when): _____

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Coronary heart disease | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Aids / related complex | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> High cholesterol / lipid levels | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> High / Low blood pressure | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Bone / joint problems | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach disease |
| <input type="checkbox"/> Cancer; type: _____ | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke / paralysis |
| | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Liver disease / hepatitis | <input type="checkbox"/> Thyroid disease |
| | | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tuberculosis |
| | | | Other: _____ |

3.) HOSPITALIZATIONS Have you been hospitalized for any other problems? Yes No (If so, please list) _____

Have you had: Appendectomy Tonsillectomy (age ____) Cholecystectomy (Gallbladder)

Other surgeries: _____

4.) FAMILY HISTORY Has any blood relative ever had: (Check all that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Alcoholism/Substance Abuse | <input type="checkbox"/> Cancer; type _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Senility |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Tuberculosis; when _____ |
| <input type="checkbox"/> Bleeding problem | | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Other _____ |

5.) MEDICINES Also include any over-the-counter medications such as vitamins, antihistamines, Tylenol, herbal remedies, etc.

6.) ALLERGIES Please check items to which you are allergic:

- Drug allergies: (specify) _____
- Food/environmental allergies (specify) _____
- Iodine - Shellfish Bee stings / Insect bites X-ray / Arteriogram or dyes Adhesive tape Latex
- Other allergies: (specify) _____
- _____

7.) IMMUNIZATIONS Check those that you have had. (Please note the most recent year received.)

- Usual childhood immunizations _____ Flu _____ Pneumonia _____ Tetanus _____
- Chicken pox _____ Hepatitis _____ Others _____

8.) HABITS

Do you exercise regularly? Yes No How? _____ How long? _____ How often? _____
Do you drink caffeinated beverages? Yes No How much? _____ Daily / Weekly How long? _____
Do you drink alcoholic beverages? Yes No How much? _____ Daily / Weekly
Type _____ How long? _____
Do you now, or have you ever used: Cigarettes Packs/Day _____ X _____ years Pipe X _____ years
 Chewing tobacco X _____ years Cocaine X _____ years
 Marijuana X _____ years If discontinued, when? _____ Others: _____
Do you regularly use a seat belt? Yes No

9.) NUTRITION ASSESSMENT

Have you recently changed the kind and/or amount of food you eat? Yes * No
If yes, was it due to: an illness? Lack of money to buy food? Trying to lose or gain weight? Other? _____
Are you on a special diet? Yes * No
If yes, what type of diet? _____
Has your weight changed 10 pounds or more in the past 6 months? Yes * No
Amount gained _____ or lost _____
Do you have diabetes? Yes * No
Have you seen a dietician in the past year? Yes No *
Do you take an herbal, vitamin/mineral, nutritional drinks or supplements? Yes No
If yes, what? _____
Would you like more information about healthy eating? Yes * No

* May indicate referral to dietician

10.) GENERAL SCREEN / SREVIEW OF SYSTEMS

Please indicate any of the following problems which you might have right now.

- | | | |
|---|---|---|
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Enlarged veins in legs | <input type="checkbox"/> Swelling hands, feet, ankles |
| <input type="checkbox"/> Breast masses/discharge | <input type="checkbox"/> Family/work problems | <input type="checkbox"/> Trouble breathing-exercise or lying down |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Fever | <input type="checkbox"/> Trouble with ears/hearing |
| <input type="checkbox"/> Calf cramps, walking or at night | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Trouble with eyes |
| <input type="checkbox"/> Chest pain/discomfort | <input type="checkbox"/> Loose stools | <input type="checkbox"/> Trouble with nose-bleeding, congestion |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of height | <input type="checkbox"/> Trouble with stomach digestion |
| <input type="checkbox"/> Coughing spells/lots of phlegm | <input type="checkbox"/> Loss of urine | <input type="checkbox"/> Trouble with urination |
| <input type="checkbox"/> Crying spells/depression | <input type="checkbox"/> Mouth/throat swelling | <input type="checkbox"/> Unusual fatigue |
| <input type="checkbox"/> Difficulty starting urinary stream | <input type="checkbox"/> Palpitations, unusual heartbeats | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Sudden loss of vision | <input type="checkbox"/> Weight change |
| <input type="checkbox"/> Dizzy spells/blackouts | | <input type="checkbox"/> Other: _____ |

Last Dental Exam: _____ Last Vision Exam: _____ Last Rectal Exam / Colonoscopy: _____

11.) PAIN ASSESSMENT (Please indicate body site, intensity of pain, things that make your pain better or worse)

Body Site: _____ No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Worst Pain Imaginable
What makes this pain better? (ie. rest, heat, medicine): _____
What makes this pain worse? (ie. walking, standing, lifting): _____

12.) SEXUAL HISTORY (Men & Women)

Are you sexually active: Yes No Lifetime number of partners: _____
Current contraception method or protection against STD: _____ Any sexual dysfunction or pain? _____
Any sexual concerns or questions? _____

13.) MEN ONLY Last rectal exam: _____ Last PSA: _____

Practicing monthly testicular exam: Yes No Need information Difficulty urinating: _____

14.) WOMEN ONLY

Last menstrual period: _____ Pain/bleeding after sex: Yes No
Age at onset: _____ Regular Irregular Pregnant: Yes No
Flow: Heavy Moderate Light Length of periods: _____ Planning pregnancy: Yes No
Pain/cramps with menses: Yes No Number of pregnancies: _____
Days of flow (number): _____ Number of ectopic pregnancies: _____
Length of cycle: _____ Number of live births: _____
Last Pap smear: _____ Number of miscarriages: _____ Number of abortions: _____
Last mammogram: _____ Contraception method: _____
Monthly self breast exam: Yes No Name of birth control pill if using: _____
Menopause: Yes No Age: _____ Any concerns or questions? _____
Symptoms of menopause: _____

I reviewed, agree and/or made changes as necessary to form: Provider Signature: _____ Initial: _____ Date: _____