Adult Medical History Form

_____ _____

Name *Date*

Please complete all pages

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you**!

PRESENT HEALTH CONCERNS: _____

_____

_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs

Medication	Dose	Times/Day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

____Congenital Heart disease:
Specify type _____
____Myocardial Infarction (Heart attack)
Specify date _____
____Hypertension (High blood pressure)
____Diabetes
____High cholesterol
____Stroke
Specify date _____
____Thyroid problem
*Specify type*_____
____Coagulation (bleeding/clotting) disorder
____Cancer (Malignancy – Benign, Carcinoma)
*Specify type*_____
____Depression
____Alcoholism
____If you have ever had a blood transfusion
Specify date _____
_____Abnormal Pap smear
_____Other problems: _____, _____, _____

SURGICAL HISTORY: (Please list all prior operations and dates)

Operation	Date

WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies: ____ # deliveries: ____ # abortions: ____ # miscarriages: _____
1st day of most recent period: _____ Age at 1st period: ____
Frequency of periods: _____ Length of each: _____
Do you have any concerns about your periods? __ No __ Yes: _____
Do you have any concerns about menopause? __ No __ Yes: _____

EXERCISE:

Do you exercise regularly? ___ No ___ Yes
How often do you exercise? ____ times per week
What do you do for exercise? _____

FAMILY HISTORY:

Please indicate with a check (√) family members who have had any of the following conditions

Medical Condition	Mom	Dad	Bro.	Sis.	Daug.	Son	Other close relatives
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, skin (except melanoma)							
Cancer, Ovary							
Cancer, Prostate							
Cancer (any other not listed)							
Depression							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy (seizures)							
Genetic diseases							
Glaucoma							
Hay Fever (Allergic Rhinitis)							
Hearing problems							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure (Hypertension)							
High cholesterol							

Kidney Disease							
Lupus							
Mental retardation							
Migraine Headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other							

SUBSTANCE USE:

Tobacco Use

Cigarettes

___ Quit: Date_____

___ Never

___ Current: Smoker: packs/day___ # of yrs

___

Other Tobacco: ____ Pipe _____ Cigar

____ Snuff _____ Chew

Are you interested in quitting?

____ No ____ Yes

Alcohol Use

Do you drink alcohol? ____ No ____ Yes

drinks/week _____

Is alcohol use a concern for you or others?

____ No ____Yes

Drug Use

Do you use recreational drugs?

____ No____ Yes

Have you ever used needles? ___ No __ Yes

SOCIOECONOMICS:

Occupation: _____

Education completed: ___ Grade school ___ High school ___ College ___ Graduate school

Years of education _____

In the US___ Outside the US___

Marital status: __Single __Married __Separated __Divorced __Widowed __Cohabitating

__Engaged __Other: _____

Spouse/Partner's name: _____

Number of children: _____

Who lives at home with you? _____

SEXUALITY:

Sexual Activity
Sexually active: __ Yes __ No __ not currently
Current sex partner(s) is/are: __ male __ female

Contraception and Protection
Birth Control method: _____ None needed____
If sexually active, do you practice safe sex? __ NA __ No __ Yes
Have you ever had any sexually transmitted diseases (STDs)? __ No __ Yes
If yes, please include: _____date_____
_____date_____
Are you interested in being screened for sexually transmitted diseases? __ No __ Yes
Other concerns? _____

SAFETY:

Do use seatbelts consistently? __ No __ Yes
Do you wear a bike helmet regularly? __ NA __ No __ Yes
Is violence at home a concern for you? __ No __ Yes
Do you feel safe in your current relationship? __ NA __ No __ Yes
Do you have a gun in your home? __ No __ Yes
Other concerns? _____

EMOTIONS:

1. In the past year have you had 2 weeks or more during which you felt sad or depressed or when you lost all interest or pleasure in things you usually care about or enjoy? __ No __ Yes
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? __ No __ Yes
3. Have you felt depressed or sad much of the time in the past year? __ No __ Yes

IMMUNIZATIONS: Please give best estimate of the month and year of each immunization:

Hepatitis A _____ Measles _____ Mumps_____ Rubella_____

Hepatitis B _____ MMR _____ Pneumovax (Pneumonia) _____

Tetanus (Td) _____ Varicella shot or Chicken Pox _____ Other _____

REVIEW OF SYSTEMS: Please check (√) any problems you are currently having on the list below:

Constitutional
__Fevers/chills/sweats
__Unexplained weight loss/gain
__Fatigue/weakness
__Excessive thirst or urination

Eyes
__Change in vision

Ears/Nose/Throat/Mouth
__Difficult hearing/ ringing ears
__Problems with teeth/gums
__Hay fever/allergies

Cardiovascular
__Chest pain/discomfort
__Leg pain with exercise
__Palpitations

Chest (breast)
__Breast lump/discharge

Respiratory
__Cough/wheeze
__Difficulty breathing

Gastrointestinal
__Abdominal pain
__Blood in bowel movement
__Nausea/vomiting/ diarrhea

Genitourinary
__Nighttime urination
__Leaking urine
__Unusual vaginal bleeding
__Discharge: penis or vagina
__Sexual function problems

Musculo-skeletal
__Muscle/joint pain

Skin
__ Rash
__Mole change

Neurological
__Headaches
__Dizziness/light-headedness
__Numbness
__Memory loss
__Loss of coordination

Psychiatric
__Anxiety/stress
__Problems with sleep
__Depression

Blood/Lymphatic
__Unexplained lumps
__Easy bruising/bleeding
Other (specify) _____

Health Insurance Information Form

[Please fill out one form for each member of the family that has insurance]

Name: _____

Date of Birth: _____ Gender: _____Male _____Female

Home Address: _____

Home Phone: _____

Work Phone: _____ Cell Phone: _____

Email Address: _____

INSURANCE INFORMATION

Insurance Carrier: _____

Policy Number: _____

Group Number: _____

Insurance Address: _____

Insurance Phone Number: _____

Name of Policy Holder (other than self): _____

Address of Policy Holder: _____

In Case of Emergency (ICE contact information)

Name of Person to Notify: _____

Relationship to You:_____

Phone Number: _____