Adult Medical History

Name_____ Date of Completion _____DOB_____

PRESENT HEALTH CONCERNS: _____

_____

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

Medication, Herb or OTC	Strength	How Often

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication Reaction or Side Effect: _____

PERSONAL MEDICAL HISTORY:

Year _____Congenital Heart
_____MI Heart Attack
_____High blood pres
_____Diabetes
_____High cholesterol

_____Depression
_____Suicide Attempt
_____Transfusion
_____Abnormal Pap Smear
_____Stroke

_____Cancer/Type_____
_____Thyroid Problem
_____Clotting Disorder

SURGICAL HISTORY

Year	Surgery	Year	Surgery

WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies: ____ # deliveries: ____ # abortions: ____ # miscarriages: _____
1st day, 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: _____
Last Mammogram_____ Last Pap Smear_____

SOCIAL HISTORY

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 any recreational drugs? • No • Yes
Have you ever used needles? • No • Yes

EXERCISE:
Do you exercise regularly? • No • Yes

VACCINATIONS (please insert year):

Tetanus _____
Measles Mumps Rubella_____
Hepatitis A_____
Hepatitis B_____
Varicella (Chicken Pox) _____
Pneumovax _____

SOCIOECONOMICS:

Occupation: _____
Education completed: • GS HS College Grad Prof School
Years of education ____

Marital status: • Single • M • Sep • D • W • Co-habiting
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? 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

SAFETY:

Do use seatbelts consistently? • No • Yes

Do you use a bike helmet regularly? • No • Yes

Is violence at home a concern for you? • No • Yes

Do you feel safe in your current relationship? 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, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? No • Yes

2. Have you had 2 years or more in your life when you been Depressed or sad most days, even if you felt ok sometimes? • No • Yes

3. Have you felt depressed or sad much of the time in the past year? No Yes

REVIEW OF SYSTEMS: Please check (X) any current problems you have 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 in 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
Musculoskeletal
___Muscle/joint pain
Skin
___ Rash or 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 (please specify)
_____
_____

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

__Diabetes M F MGM MGF PGM PGF Other_____

__Easy Bleeding M F MGM MGF PGM PGF Other_____

__Obesity M F MGM MGF PGM PGF Other_____

__Allergy M F MGM MGF PGM PGF Other_____

__Hypertension M F MGM MGF PGM PGF Other_____

__Jaundice M F MGM MGF PGM PGF Other_____

__Gout M F MGM MGF PGM PGF Other_____

__Cholesterol M F MGM MGF PGM PGF Other_____

__Stroke M F MGM MGF PGM PGF Other_____

__Alcoholism M F MGM MGF PGM PGF Other_____

__Asthma M F MGM MGF PGM PGF Other_____

__Breast Cancer M F MGM MGF PGM PGF Other_____

__Colon Cancer M F MGM MGF PGM PGF Other_____

__Cancer(type)_____M FMGM MGF PGM PGF Other_____

__Heart Trouble M F MGM MGF PGM PGF Other_____

__Tuberculosis M F MGM MGF PGM PGF Other_____

__Depression M F MGM MGF PGM PGF Other_____

_Suicide M F MGM MGF PGM PGF Other_____