

## Adult Medical History Form

Please complete ALL PAGES

\_\_\_\_\_  
Name

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)

\_\_\_ Hypertension (High blood pressure)

\_\_\_ Diabetes

- High cholesterol
- Stroke
- Thyroid problem  
Specify type \_\_\_\_\_
- Coagulation (bleeding/clotting) disorder
- Cancer (Malignancy)  
Specify type \_\_\_\_\_
- Depression/suicide attempt
- Alcoholism
- If you have ever had a blood transfusion  
Please specify date \_\_\_\_\_
- Abnormal Pap smear

Other problems \_\_\_\_\_

When was your last Tetanus shot?

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

Operation	Date

**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: \_\_\_\_\_

**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 (not noted)							
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 (Hyperlipidemia)							
Kidney Disease							
Lupus (Systemic Lupus Erythematosus)							
Mental retardation							
Migraine Headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other							

**SOCIAL HISTORY: SUBSTANCES**

**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

**SOCIOECONOMICS:**

Occupation: \_\_\_\_\_

Education completed: \_\_\_ Grade school \_\_\_ High school \_\_\_ College \_\_\_ Graduate school

Years of education \_\_\_\_\_

Marital status: \_\_\_ Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Co-habiting

\_\_\_ 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 use 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, 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 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 list your most recent immunizations. Please include your best estimate of the month and year of each immunization:

- |                                       |   |                                |                                  |  |
|---------------------------------------|---|--------------------------------|----------------------------------|--|
| Hepatitis A <input type="checkbox"/>  | Measles <input type="checkbox"/>                      | Mumps <input type="checkbox"/> | Rubella <input type="checkbox"/> | Pneumovax (Pneumonia) <input type="checkbox"/> |
| Hepatitis B <input type="checkbox"/>  | MMR <input type="checkbox"/>                          |                                |                                  |  |
| Tetanus (Td) <input type="checkbox"/> | Varicella (chicken pox) shot <input type="checkbox"/> |                                |                                  | Other <input type="checkbox"/>                 |

**REVIEW OF SYSTEMS:** Please check (✓) any current problems you have on the list below.

- |  |   |   |
|--|---|---|
| <b>Constitutional</b>                                    | <b>Chest (breast)</b>                               | <b>Skin</b>   |
| <input type="checkbox"/> Fevers/chills/sweats            | <input type="checkbox"/> Breast lump/discharge      | <input type="checkbox"/> Rash or mole change        |
| <input type="checkbox"/> Unexplained weight loss/gain    | <b>Respiratory</b>                                  | <b>Neurological</b>                                 |
| <input type="checkbox"/> Fatigue/weakness                | <input type="checkbox"/> Cough/wheeze               | <input type="checkbox"/> Headaches                  |
| <input type="checkbox"/> Excessive thirst or urination   | <input type="checkbox"/> Difficulty breathing       | <input type="checkbox"/> Dizziness/light-headedness |
| <b>Eyes</b>  | <b>Gastrointestinal</b>                             | <input type="checkbox"/> Numbness                   |
| <input type="checkbox"/> Change in vision                | <input type="checkbox"/> Abdominal pain             | <input type="checkbox"/> Memory loss                |
| <b>Ears/Nose/Throat/Mouth</b>                            | <input type="checkbox"/> Blood in bowel movement    | <input type="checkbox"/> Loss of coordination       |
| <input type="checkbox"/> Difficult hearing/ ringing ears | <input type="checkbox"/> Nausea/vomiting/diarrhea   | <b>Psychiatric</b>                                  |
| <input type="checkbox"/> Problems with teeth/gums        | <b>Genitourinary</b>                                | <input type="checkbox"/> Anxiety/stress             |
| <input type="checkbox"/> Hay fever/allergies             | <input type="checkbox"/> Nighttime urination        | <input type="checkbox"/> Problems with sleep        |
| <b>Cardiovascular</b>                                    | <input type="checkbox"/> Leaking urine              | <input type="checkbox"/> Depression                 |
| <input type="checkbox"/> Chest pain/discomfort           | <input type="checkbox"/> Unusual vaginal bleeding   | <b>Blood/Lymphatic</b>                              |
| <input type="checkbox"/> Leg pain with exercise          | <input type="checkbox"/> Discharge: penis or vagina | <input type="checkbox"/> Unexplained lumps          |
| <input type="checkbox"/> Palpitations                    | <input type="checkbox"/> Sexual function problems   | <input type="checkbox"/> Easy bruising/bleeding     |
|  | <b>Musculo-skeletal</b>                             | <b>Other (specify) _____</b>                        |
|  | <input type="checkbox"/> Muscle/joint pain          |   |