MEDICAL HISTORY: ADULT

Name:_____ Date:_____

Past Medical History and Current Concerns **For instance, high blood pressure, asthma, diabetes.**

Past Surgical History **Please include procedures and year performed.**

Procedure	Year	Procedure	Year	Procedure	Year

Medications **Please include any prescription medications, herbal medications, and supplements or vitamins. Also indicate dosage and how often taken (eg, daily, twice a day)**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies **Please include any medicinal, food or environmental allergies.** ☐ **No known drug allergies**

_____ _____ _____

Immunizations

When was your last Tetanus shot? _____ or **UNKNOWN**
Have you had any other immunizations like Hepatitis A, Hepatitis B (series of 3 shots), Shingles, Pneumonia? **YES** or **NO**
If yes, what year?_____

Social History

Do you smoke? **YES** or **NO** If yes, how many packs per day and for how many years? _____ If you quit, when and after how many years of smoking?_____ Do you drink alcohol? **YES** or **NO** If yes, how many drinks per week?_____
Number of caffeinated beverages daily: _____
Any current or previous drug use? **YES** or **NO** If yes, what substance(s)? _____
Occupation:_____
Please circle: *Single Married Partnered Divorced Widowed*
Household occupants (number and relationship): _____
_____
Please circle: *Heterosexual Homosexual Bisexual Other Identity*
History of sexually transmitted diseases? **YES** or **NO** Please circle: *Herpes Chlamydia Gonorrhea HPV Syphillis*
Do you have any children? **YES** or **NO** Names: _____
Regular exercise: **YES** or **NO** What activity and how often?_____
Any pets? **YES** or **NO** Kind of pet(s)?_____
Have you been a victim of abuse? **YES** or **NO** Any firearms in the home? **YES** or **NO** Smoke detectors in the home? **YES** or **NO**

Preventative Health

Colonoscopy date and how many years until repeat needed? _____

Last Pap smear and any previous abnormal?_____ Last mammogram?_____

Last cholesterol test and results?_____

Last eye exam?_____

Last HIV test? _____

Family History

GM=grandmother, GF=grandfather

	Mother	Father	Sister	Brother	Mat GM	Mat GF	Pat GM	Pat GF	Other relative (write in which one)
Heart disease (e.g. heart attacks, congestive heart failure)									
Abnormal heart rhythm (e.g. atrial fibrillation)									
Unexplained death before 50									
High cholesterol									
Hypertension									
Stroke									
Diabetes									
Breast Cancer									
Colon Cancer									
Colon polyps									
Lung Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer (write in type)									
Dementia									
Asthma									
Allergic rhinitis									
COPD/emphysema									
Rheumatoid arthritis									
Osteoarthritis									
Osteoporosis									
Hypothyroidism (underactive)									
Hyperthyroidism (overactive)									
Alcoholism/Substance Abuse									
Depression									
Anxiety									
Suicide									
Trauma									
Migraines									
Glaucoma									
Kidney disease									
Parkinson's disease									
Other illness (write in)									