MEDICAL HISTORY: ADULT

Name:_____ Date:_____

Concerns you would like to address today:

_____
_____
_____

Past Medical History **Please list your history of medical conditions or diagnoses, e.g. high BP, asthma, diabetes.**

Medical Diagnoses	Mental Health Conditions	Prior Hospitalizations

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 (e.g, daily, twice a day)**

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

Immunizations

When was your last Tetanus shot? _____ or **UNKNOWN**

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 Syphilis*

Do you have any children? **YES** or **NO** How many?_____

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?_____

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)									
Atrial fibrillation									
Other arrhythmia									
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)									
Other Cancer (write in type)									
Dementia									
Asthma									
Allergic rhinitis									
COPD/emphysema									
Rheumatoid arthritis									
Osteoarthritis									
Osteoporosis									
Hypothyroidism (underactive)									
Hyperthyroidism (overactive)									
Alcohol use disorder									
Substance use disorder									
Depression									
Anxiety									
Suicide									
Migraines									
Glaucoma									
Kidney disease									
Parkinson's disease									
Other illness (write in)									