Doctors' Clinic Adult Medical History Form

(Ages 19 and older)

Your answers on this form will help your doctor 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!**

NAME: ________________________ **AGE:** ________ **DATE of BIRTH:** ___________

What is the primary reason you are seeing the doctor today:______________________________

If time allows, what other issues would you like to discuss with the doctor?

1)______________________________ 2)______________________________

MEDICATIONS: Prescription and non-prescription medications, inhalers, birth control pills, vitamins, supplements:

Medication	Dose (eg. mg/pill)	How many times per day	Prescribed by whom:

MEDICATION ALLERGIES: ____None ____Aspirin ____Penicillin ____Sulfa Other: _______

What type of reaction did you have?______________________________

Date of most recent **IMMUNIZATIONS**:

______Hepatitis B
______Pneumovax (Pneumonia)
______MMR
______Varicella (chicken pox): shot or Illness? _______
______Influenza (Flu Shot)
______Meningitis
______Tetanus (Td)
______Tetanus (Tdap)
______Hepatitis A
______Zoster (Shingles)

PERSONAL MEDICAL HISTORY:

Please check (X) if you have had any of the following medical problems:

____Allergies
____Anemia
____Angina
____Anxiety
____Arthritis
____Asthma
____Atrial fibrillation
____BPH
____Blood clots
____Cancer, type:_____
____Stroke
____COPD
____Heart disease, type:__________
____Crohn's disease
____Depression
____Diabetes, type:___
____Gallbladder disease
____GERD
____Hepatitis C
____High cholesterol
____Hypertension
____IBS
____Liver disease
____Migraines
____Heart attack
____Osteoarthritis
____Osteoporosis
____Peptic ulcer disease
____Kidney disease
____Seizure disorder
____Thyroid disease

Other problems (specify):______________________________

SURGICAL HISTORY:

Please circle or write in any surgeries or procedures which you have had. **Indicate the year** of the procedure in the space.

______Angioplasty
______Heart stent
______Appendectomy
______Knee scope
______Back surgery
______Open-heart surgery
______Carpal tunnel
______Cataract surgery
______Gall bladder
______Colon resection
______Colostomy
______Gastric bypass
______Hernia repair type_________
______Hip replacement
______Knee replacement
______LASIK
______Liver biopsy
______Broken bone surgery
______Pacemaker
______Small bowel resection
______Thyroidectomy
______Tonsillectomy
______Prostate biopsy
______TURP
______Vasectomy
______Breast Augmentation
______Tubes tied
______Breast biopsy
______Cesarean section
______D and C
______Hysterectomy type:_________
______Mastectomy
______Myomectomy
______Breast reduction

Other surgeries (specify type and year):______________________________

____

FEMALE HISTORY: Age at 1st period: ______ Age at 1st birth_____ First day of most recent period: _________

Menopause? ___Yes ___No Age or year at menopause?______ Natural menopause? ___Yes ___No

Currently pregnant? ___ Yes ___ No ___ possibly

Pregnancy history: #full term:___ #preterm:___ #c-section:___ # vaginal deliveries:___ #live births:___

#currently living:___ #ectopic pregnancies___ #miscarriages:___ #abortions:___

(over)

(Rev. 12/09)

FAMILY HISTORY: Please indicate any family history of the following:

Diagnosis	Family member(s)	Age at onset	Living?
ADD/ADHD			
Alcoholism			
Allergies			
Alzheimer's disease			
Asthma			
Blood disease			
Heart disease			
Cancer, type:_________			
Stroke			
Depression			
Developmental delay			
Diabetes			
Eczema			
Hearing deficiency			
Elevated cholesterol			
High blood pressure			
Irritable bowel disease			
Learning disability			
Mental illness			
Migraines			
Obesity			
Osteoarthritis			
Osteoporosis			
Peripheral vascular disease			

Other family history (please specify):____

SOCIAL HISTORY: Education level:____________________ Degree obtained:____________________
Occupation:________________________ Employer:________________________ Status: part-time full-time retired
Marital Status: ____________ Previously widowed?___ Previous divorce?___ Children? #boys___ #girls___
Current tobacco use?____ Previous tobacco use?____ Type of tobacco?__________ #packs/cans/bowls per day:_____
#years used tobacco____ Year quit or attempted to quit______
Do you drink alcohol? ___ Did you previously drink alcohol?___ Type of alcohol_________ How frequently do you drink alcohol? _____ How much alcohol do you drink at a time?_______ When was your last drink?________
Do you consume caffeine? ___ What type? __________ How much caffeine do you consume per day? ___________
How active are you (circle)? vigorous moderate sedentary Are you a member of a health club?____ What type of exercise do you do? _________________________ How frequently do you exercise? # times per week____ or # hours per week_____ What hobbies or interests do you have?______________________________________
How do you describe your diet? ___healthy ___standard American diet ___junk food other:________________
Animals in the home?____ Type(s): ________________ Do you clean up after the animal?_________________
Religious affiliation?___ What religion:_____________ Do you practice your religion?___ Do you have spiritual beliefs?___
Smoke detectors in home? ___Yes ___No Type of home heating? ____________________
Carbon monoxide detectors in home? ___Yes ___No Firearms at home? ___Yes ___No type of firearms:________
Radon in the home? ___Yes ___No Do you use seatbelts consistently? ___Yes ___No
Fire extinguishers in the home? ___Yes ___No
Advanced Directives in Place?___None ___DNR ___Living will ___Durable power of attorney ___HC proxy
Date advanced directives last reviewed: _________
Confidential: Do you use any recreational drugs? ___Yes ___No ___formerly Type(s) of drugs_______ Used needles? ___Yes ___No History of child abuse? ___Yes ___No History of domestic violence? ___Yes ___No
Sexually Active? ___Yes ___No ___previously Orientation:__________ #current partners:___ #lifetime partners:___
Birth control method: _______________ History of STD? ___Yes ___No Type(s):________________________

Date of most recent HEALTH MAINTENANCE:
______Cholesterol Screening ______Stool test for blood ______Breast Exam
______PSA (Prostate) ______Pap Smear ______DEXA (bone scan)
______Colonoscopy (or sigmoidoscopy) ______Mammogram

REVIEW OF SYMPTOMS: Please check (X) any current problems you have on the list below:

Constitutional
___Fever
___Night sweats
___Weight gain
___Weight loss

Gastrointestinal
___Abdominal pain
___Change in bowel habits
___Diarrhea
___Heartburn
___Vomiting

Dermatologic
___Itching
___Rash

HEENT
___Hearing loss
___Ear pain
___Eye pain
___Vision loss

Genitourinary
___Pain with urination
___Blood in urine
___Excessive urination

Musculoskeletal
___Bone symptoms
___Joint symptoms

Respiratory
___Cough
___Shortness of breath
___Wheezing

Reproductive
___urinary incontinence
___Menstrual cramping
___Excessive menstrual bleeding
___Vaginal discharge
___Breast discharge
___Breast pain

Hematologic
___Excessive bleeding
___Easy bruising

Cardiovascular
___Chest pain
___Swelling
___Irregular heart beat

Matabolic / Endocrine
___Cold intolerance
___Heat intolerance
___Excessive thirst

Immunological
___Hay fever

Vascular
___Leg pain while walking

Neuro / Psychiatric
___Dizziness
___Weakness
___Numbness / tingling
___Depression
___Mood swings

(over)