Agave Family
Physicians, PLLC

# Adult Medical History

Patient Name : ______________________________ Date Of Birth : ____________________

**PAST MEDICAL HISTORY : (Check all that apply)**

| | | |
|---|---|---|
| ☐ Abnormal Heart Rhythm | ☐ Heart Failure | ☐ Obesity |
| ☐ Allergies | ☐ Heart Murmur | ☐ Seizure Disorder |
| ☐ Anemia | ☐ Heartburn | ☐ Skin Disorder |
| ☐ Arthritis | ☐ Hepatitis | ☐ Stroke |
| ☐ Asthma | ☐ High Blood Pressure | ☐ Thyroid Disorder |
| ☐ Cancer | ☐ High Cholesterol | ☐ Ulcer |
| ☐ Depression | ☐ HIV | ☐ ____________ |
| ☐ Diabetes | ☐ Kidney Disease | ☐ ____________ |
| ☐ Gout | ☐ Lung Disease | ☐ ____________ |
| ☐ Heart Attack | ☐ Mental Illness | ☐ ____________ |

**MEDICATIONS :**

| MEDICATION | DOSE | FREQUENCY | MEDICATION | DOSE | FREQUENCY |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**MEDICATION ALLERGIES :** ☐ no medication allergies

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**PAST SURGICAL HISTORY : (Check all that apply)**

| | | |
|---|---|---|
| ☐ Appendectomy | ☐ Hysterectomy | ☐ Ovaries Removed |
| ☐ Gallbladder Removal | ☐ Joint Replacement | ☐ Other __________ |

**FAMILY HISTORY :**

| | | | |
|---|---|---|---|
| Mother | ☐ alive (age ____) | ☐ deceased (age____) | Conditions ____________ |
| Father | ☐ alive (age ____) | ☐ deceased (age____) | Conditions ____________ |
| Sister | ☐ alive (age ____) | ☐ deceased (age____) | Conditions ____________ |
| Brother | ☐ alive (age ____) | ☐ deceased (age____) | Conditions ____________ |
| ________ | ☐ alive (age ____) | ☐ deceased (age____) | Conditions ____________ |
| ________ | ☐ alive (age ____) | ☐ deceased (age____) | Conditions ____________ |

**SOCIAL HISTORY :**

Do you drink alcohol? ☐ no ☐ yes (type ____________; drinks per day______; drinks per week _____)

Do you smoke tobacco? ☐ no ☐ yes (age started ______; packs per day ______; age quit ______)

Do you drink caffeine? ☐ no ☐ yes (type ____________; drinks per day______)

Do you regularly wear a seatbelt / wear a helmet? ☐ no ☐ yes

With whom do you live? ☐ self ☐ spouse ☐ children (ages ____________) ☐ other ____________

Do you exercise? ☐ no ☐ yes (type ______________________; times per week______)

**HEALTH MAINTENANCE :**

| | |
|---|---|
| Date of last Influenza __________ | Date of last Pap Smear __________ |
| Date of last Pneumovax __________ | Date of last Mammogram __________ |
| Date of last Tetanus __________ | Date of last Bone Densitometry __________ |
| Date of last Colonoscopy __________ | Date of last Eye Exam __________ |
| Date of last PSA __________ | Date of last Dental Exam __________ |

Signature : ______________________________ Date : ____________________