



Adult Medical History

Patient Name : _____ Date Of Birth : _____

YOUR MEDICAL HISTORY : (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer-Type _____ | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes-Type _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mental Illness _____ | <input type="checkbox"/> _____ |

MEDICATIONS :

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATION ALLERGIES: LIST DRUG AND REACTION no medication allergies

PAST SURGICAL HISTORY / HOSPITALIZATIONS: (Check all that apply and list date)

- | | | |
|--|--|--|
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Ovaries Removed _____ |
| <input type="checkbox"/> Gallbladder Removal _____ | <input type="checkbox"/> Joint Replacement _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

FAMILY HISTORY:

- | | | | |
|---------|--|---|------------------|
| Mother | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| Father | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| Sister | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| Brother | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| _____ | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |
| _____ | <input type="checkbox"/> alive (age _____) | <input type="checkbox"/> deceased (age _____) | Conditions _____ |

SOCIAL HISTORY:

What is your occupation? _____

Do you drink alcohol? no yes (type _____; drinks per day _____; drinks per week _____)

Have you ever smoked 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

Marital Status: single married divorced widowed separated other

With whom do you live? self spouse children (ages/gender _____)

Do you exercise? no yes (type _____; times per week _____)

HEALTH MAINTENANCE: (List date and document any abnormalities)

- | | | |
|-------------------|---------------------|--|
| Influenza _____ | Pap Smear _____ | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |
| Pneumovax _____ | Mammogram _____ | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |
| Tetanus _____ | Bone Density _____ | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |
| Eye Exam _____ | Colonoscopy _____ | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |
| Dental Exam _____ | Prostate Exam _____ | Normal? <input type="checkbox"/> yes <input type="checkbox"/> no _____ |

Signature: _____ Date : _____