

Adult Medical History Form

Your answers on this form will help your provider better understand your medical concerns and conditions. If you are uncomfortable with any question, **do not answer it**. Best estimates are fine if you cannot remember specific details. Thank you!

Birth date: _____ Age: _____ Sex Male Female
 How would you rate your general health? Excellent Good Fair Poor

REVIEW OF SYSTEMS: Please check any CURRENT symptoms you have.

Constitutional

- Fever
- Unexplained weight loss/gain

Eyes

- Change in vision

Ears/Nose/Throat/Mouth

- Difficulty hearing/ringing in ears
- Hay fever/allergies

Cardiovascular

- Chest pain/discomfort
- Palpitations

Breast

- Breast lump/nipple discharge

Respiratory

- Cough/wheeze

Gastrointestinal

- Blood in bowel movement
- Nausea/vomiting/diarrhea

Genitourinary

- Nighttime urination
- Leaking urine
- Unusual vaginal bleeding
- Discharge: penis or vagina

Skin

- Rash/new or changing moles

Neurological

- Weakness
- Numbness
- Headaches

Psychiatric

- Anxiety/stress
- Sleep problem
- Depression

Blood/Lymphatic

- Unexplained lumps
- Easy bruising

Musculoskeletal

- Muscle/joint pain

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? Yes No

Allergies or reactions to medicines: _____

Date of your most recent IMMUNIZATIONS:

Measles _____ Pneumovax _____ Tetanus (Td) _____

Varicella (chicken pox) shot or illness _____

HEALTH MAINTENANCE SCREENING TESTS: Please check if done, and note date and result.

- Lipid (cholesterol) Date _____ Abnormal? Yes No
- Colonoscopy Date _____ Abnormal? Yes No
- Mammogram Date _____ Abnormal? Yes No
- Pap smear Date _____ Abnormal? Yes No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

- Heart disease/heart attack _____ High blood pressure _____ Diabetes _____
 High cholesterol _____ Thyroid problem _____

Other (specify): _____

SURGICAL HISTORY: Please list all prior operations (with dates): _____

FAMILY HISTORY: Please indicate the current status of your immediate family members: (parent, siblings, or children).

- | | |
|------------------------------|---------------------------|
| Alcoholism _____ | High cholesterol _____ |
| Cancer, (specify type) _____ | High blood pressure _____ |
| Heart attack _____ | Stroke _____ |
| Depression/suicide _____ | Other _____ |
| Diabetes _____ | Other _____ |

SOCIAL HISTORY

Tobacco Use

- Cigarettes Never Quit-Date _____
 Current smoker: packs/day ___ # years ___
Other tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? Yes No

Alcohol Use

- Do you drink alcohol? No Yes-# times/wk _____
Is your alcohol use a concern for you or others?
 Yes No

Drug Use

- Do you use any recreational drugs? Yes No
Have you ever used needles to inject drugs?
 Yes No

Sexual Activity

- Sexually active: Yes No Not currently
Current sex partner(s) is/are: Male Female
Birth control method: _____ None needed
Have you ever had sexually transmitted diseases (STDs)? Yes No
Are you interested in being screened for STDs?
 Yes No

Other Concerns

SAFETY

- Do you wear your seat belt? Yes No
Is VIOLENCE at home a concern?
 Yes No
Have you ever been abused? (mentally or physically) Yes No

Exercise: Do you exercise regularly?

- Yes No
What kind of exercise? _____
How long (minutes)? _____
How often? _____

Diet

- How do you rate your diet?
 Good Fair Poor