

**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