Adult Medical History Form

please print

Appointment Date: ____________

Patient Name: ____________________________ Date of Birth: __________________

> *Complete entire form unless you have previously completed this form, in which case you may complete only items with an asterisk and any others that may have changed such as a change in marital status.

***Reason for visit or current problem**:
(Include date of onset or injury)______________

Past medical problems:__________________

Hospitalizations and operations: Year

Women- Menstrual history & pregnancies:
Age at first menses: ______________________
*Date of last menses:______________________
*Length of cycle, start to start (days): ________
*Length of flow (days):_____________________
*Current contraception:____________________
Age of menopause: _______________________
Total pregnancies:_______ Live births:________
Miscarriages:___________ Terminations:______
Date of last PAP:__________________________
Date of last Mammogram:__________________

Risk factors: (check all boxes that apply)
*Tobacco:
□ Never
□ Former: years smoked ________year quit____
□ Current: year started _______________
□ Cigarettes: packs per day________________
□ Cigars: number per week_________________
□ Smokeless: cans per wk_________________
□ Second hand smoke exposure
*Drug use: □ No □ Yes: list _____________

*HIV high risk behavior: □ No □ Yes
*Caffeine: □ No □ Yes: drinks/day _________
*Alcohol: □ No □ Yes: drinks/day __________
*Exercise: times per week ________________
Type_________________________________
*Seat belt use: □ always □ usually □ sometimes □ never
Sun exposure: □ frequent □ occasional □ rare
Last Colonoscopy:_________________________
Last Tetanus Booster:______________________

***Medications and doses**: □ No change

***Allergies**: (include reaction)______________

Family History: (list relative)
Alcoholism:_______________________________
Asthma:__________________________________
Depression/suicide: _______________________
Diabetes:_________________________________
Heart disease:_____________________________
High blood pressure:________________________
High cholesterol:___________________________
Osteoporosis:______________________________
Stroke:___________________________________
Breast cancer:_____________________________
Colon cancer:______________________________
Ovarian cancer:____________________________
Prostate cancer: ___________________________

Social History:
Marital status: (circle) single married separated divorced widowed live w/partner
History of domestic abuse: □ No □ Yes

Children: (first name and year born)

Occupation: (present or previous) □ Retired

Education completed: (circle) high school College/tech grad/professional

Religion affects health care: □ No □ Yes
Explain:__________________________________

Review of Systems

Please check any symptoms you are experiencing.

General

- ______ Chills
- ______ Daytime Sleepiness
- ______ Fatigue
- ______ Fever
- ______ Loss of Appetite
- ______ Night Sweats
- ______ Severe Snoring
- ______ Trouble sleeping
- ______ Unexpected Weight Loss

Ears / Nose / Throat

- ______ Decreased Hearing
- ______ Difficulty Swallowing
- ______ Ear Discharge
- ______ Earache
- ______ Face or Jaw Pain
- ______ Hoarseness
- ______ Nasal Congestion
- ______ Nosebleeds
- ______ Post Nasal Discharge
- ______ Ringing in the Ears
- ______ Sore Throat

Breast

- ______ Abnormal Mammogram
- ______ Breast Enlargement
- ______ Breast Pain
- ______ Breast Lump
- ______ Nipple Discharge

Eyes

- ______ Blurred Vision
- ______ Discharge From Eye
- ______ Double Vision
- ______ Eye Irritation
- ______ Eye Pain
- ______ Light Sensitivity
- ______ Loss of Vision

Cardio-vascular

- ______ Chest Pain or Discomfort
- ______ Calf Pain with Walking
- ______ Difficulty Breathing at Night
- ______ Difficulty Breathing Laying Down
- ______ Fainting or Near Fainting
- ______ Leg Cramps
- ______ Lightheadedness
- ______ Palpitations or Racing Heart
- ______ Recent Weight Gain
- ______ Shortness of Breath with Exertion
- ______ Swelling in Feet or Legs

Respiratory

- ______ Chest Pain with Deep Breaths
- ______ Cough
- ______ Coughing Up Blood
- ______ Excessive Mucus or Phlegm
- ______ Excessive Snoring
- ______ Shortness of Breath
- ______ Wheezing

Gastro-Intestinal

- ______ Abdominal Bloating
- ______ Abdominal Pain
- ______ Bloody Stools
- ______ Change in Bowel Habits
- ______ Constipation
- ______ Dark Tarry Stools
- ______ Diarrhea
- ______ Difficulty swallowing
- ______ Heartburn
- ______ Hemorrhoids
- ______ Indigestion
- ______ Nausea
- ______ Pain with swallowing
- ______ Vomiting
- ______ Vomiting Blood
- ______ Yellowish Skin Color

Genitourinary - WOMEN

- ______ Blood in Urine
- ______ Decreased Sex Drive
- ______ Vaginal Discharge
- ______ Pain with urination
- ______ Genital Sores
- ______ Heavy or Prolonged Periods
- ______ Hot Flashes
- ______ Irregular or Missed Periods
- ______ Night time urination
- ______ Pain with Intercourse
- ______ Painful Periods
- ______ Pelvic Pain
- ______ Spotting
- ______ Trouble starting Urine
- ______ Frequent Urination
- ______ Urinary Urgency
- ______ Leaking Urine

Dermatology

- ______ Change in Hair or Nails
- ______ Dry Skin
- ______ Excessive Perspiration
- ______ Itching
- ______ Non-Healing sores
- ______ Rash
- ______ Suspicious Mole or Growth
- ______ Unusual Hair Distribution

Psych

- ______ Anxious Mood
- ______ Depressed Mood
- ______ Excessive Worrying
- ______ Fears or Phobias
- ______ Frightening Visions or Sounds
- ______ Sleep Problems
- ______ Thoughts of Suicide
- ______ Thoughts of Violence to Others

Endo

- ______ Cold Intolerance
- ______ Excessive Hunger
- ______ Excessive Thirst
- ______ Excessive Urination
- ______ Heat Intolerance
- ______ Weight Change

Genitourinary - MEN

- ______ Blood in Urine
- ______ Decreased Sex Drive
- ______ Discharge From Penis
- ______ Pain with urination
- ______ Erectile Dysfunction
- ______ Genital Sores
- ______ Night time urination
- ______ Trouble Starting Urine
- ______ Frequent Urination
- ______ Urinary Urgency
- ______ Leaking Urine

Musculoskeletal

- ______ Neck Pain
- ______ Upper Back Pain
- ______ Low Back Pain
- ______ General Weakness
- ______ Joint Pain
- ______ Joint Swelling
- ______ Muscle Aches
- ______ Muscle Cramps
- ______ Muscle Weakness
- ______ Stiffness

Neurological

- ______ Arm & Leg Weakness
- ______ Confusion
- ______ Dizziness or Senation of Spinning
- ______ Facial Weakness
- ______ Falling Down
- ______ Headaches
- ______ Loss of Consciousness
- ______ Numbness or Tingling
- ______ Poor Balance or Coordination
- ______ Poor Memory
- ______ Seizures or Uncontrolled Movements
- ______ Slurred Speech
- ______ Tremors
- ______ Trouble with Concentration
- ______ Visual Disturbances

Heme

- ______ Enlarged Glands
- ______ Excessive or Easy Bruising

Allergy

- ______ Hives or Rash
- ______ Persistent Infections
- ______ Possible HIV Exposure
- ______ Seasonal Allergies