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: _____

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: _____
Date of last Mammogram: _____
Last Tetanus Booster: _____

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

***Allergies**: (include reaction) _____

Family History: (list relative)
Alcoholism: _____
Asthma: _____
Depression/suicide: _____
Diabetes: _____
***Heart attack < 65 yr. old female:** _____
***Heart attack < 55 yr. old male:** _____
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: _____

Patient's Name: _____

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
- Possible HIV Exposure

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

Infectious Disease

- HIV Exposure

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
- Possible HIV Exposure

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 Sensation 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
- Seasonal Allergies