Adult Medical History Form

please print

Appointment Date:

Patient name: _____ DOB: ___/___/___

* 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 & 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 that apply*

*Tobacco:
☐ Never
☐ Former: years smoked _____ year quit _____
☐ Current: year started _____
☐ Cigarettes: packs per day? _____
☐ Cigars: number per week _____
☐ Smokeless: cans per week _____
☐ Second hand smoke exposure
*Drug Use: ☐ No ☐ Yes List: _____

*HIV high risk behavior: ☐ No ☐ Yes
*Caffine: ☐ No ☐ Yes drinks per day:
*Alcohol: ☐ No ☐ Yes drinks per day:
*Exercise: Times per week _____
Type(s): _____
*Seat belt use: ☐ always ☐ usually ☐ sometimes ☐ never
Sun exposure: ☐ frequent ☐ occasional ☐ rare
Last colonoscopy: _____
Date of last mammogram: _____
Last tetanus booster: _____

Medication & doses: ☐ No Change

Allergies: (Include reaction)

Family History: List relative
Alchoholism: _____
Asthma: _____
Depression/suicide: _____
Diabetes: _____
*Heart attack < 65 yr. female: _____
*Heart attack < 55 yr. male: _____
High blood pressure: _____
High cholesterol: _____
Osteroporosis: _____
Stroke: _____
Breast cancer: _____
Colon cancer: _____
Ovarian cancer: _____
Prostate cancer: _____

Social History:
Marital status: *(circle)* single married seperated 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 one) 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

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Heme

- Enlarged Glands
- Excessive or Easy Bruising

Allergy

- Hives or Rash
- Persistent Infections
- Seasonal Allergies