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: _____

Western Washington Medical Group

Name:_____ Date:_____ DOB:_____

REVIEW OF SYSTEMS (Check any of the following symptoms you <u>have in the past 6 months</u>)

Constitutional

- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Fatigue/Malaise
- ☐ Fever
- ☐ Sweating
- ☐ Unexplained weight change

HENT

- ☐ Congestion
- ☐ Dental Problems
- ☐ Difficulty swallowing
- ☐ Drooling
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Facial Swelling
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Post Nasal Drip
- ☐ Ringing in the ears
- ☐ Runny nose
- ☐ Sinus pain
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore throat
- ☐ Voice change

Eyes

- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Sensitivity to light
- ☐ Visual disturbance

Cardiovascular

- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations

Respiratory

- ☐ Apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stridor
- ☐ Wheezing

Gastrointestinal

- ☐ Abdominal distention
- ☐ Abdominal pain
- ☐ Anal Bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Dark/tarry stools
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Genitourinary

- ☐ Bed Wetting
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Flank pain
- ☐ Genital discharge
- ☐ Genital pain
- ☐ Genital sore
- ☐ Menstrual problems
- ☐ Pain with urination
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Vaginal bleeding
- ☐ Vaginal pain

Musculoskeletal

- ☐ Back pain
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle aches
- ☐ Neck pain
- ☐ Neck stiffness

Endocrine

- ☐ Cold intolerance
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Heat intolerance

Hematology

- ☐ Bruise/bleed easily
- ☐ Swollen lymph nodes

Allergy/Immune System

- ☐ Food allergies
- ☐ Environmental allergies
- ☐ Immunocompromised

Skin

- ☐ Color change
- ☐ Rash
- ☐ Wound

Neurologic

- ☐ Dizziness
- ☐ Headaches
- ☐ Light-headedness
- ☐ Loss of Consciousness
- ☐ Numbness/tingling
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Tremor
- ☐ Weakness

Psychiatric

- ☐ Agitation
- ☐ Behavior problem
- ☐ Confusion
- ☐ Depression
- ☐ Decreased concentration
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Insomnia/Sleep problems
- ☐ Nervous/Anxious
- ☐ Thoughts of suicide/self harm

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**