
Name

Date

Adult Medical History Form

Your answers on this form will help your provider better understand your medical concerns and conditions better. This form will NOT be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

AGE _____ How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Other concerns I would like to discuss if there is time: _____

REVIEW OF SYMPTOMS: Please check any CURRENT symptoms you have.

Constitutional

____ Fevers/sweats/weakness
____ 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

Musculoskeletal ____ Muscle/joint pain

Skin ____ Rash/new or change in mole

Neurological ____ Headaches

____ Memory loss

Psychiatric ____ Anxiety/stress

____ Sleep problem

____ Depression

Blood/Lymphatic ____ Unexplained lumps

____ Easy bruising/bleeding

Other ____ Concern with sexual function

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? Yes No

Medications: Please Complete Med List Form

ALLERGIES or REACTIONS TO MEDICINES: _____

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ Measles _____ Pneumovax (pneumonia) _____

Rubella _____ Tetanus (Td) _____ Varicella (chicken pox) shot or illness _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) _____ Date _____ Abnormal? Yes No

Sigmoidoscopy _____ or Colonoscopy _____ Date _____ Abnormal? Yes No

Women: Mammogram _____ Date _____ Abnormal? Yes No Pap Smear _____ Date _____ Abnormal? Yes No

Men: PSA (prostate) _____ Date _____ Abnormal? Yes No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

____ Heart disease: _____ High blood pressure _____ High cholesterol
 specify type _____ Diabetes _____ Thyroid problem
____ Heart attack (412) _____ Other: (specify): _____

SURGICAL HISTORY: Please list all prior operations (with dates).

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

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 _____ # of yrs _____
Other Tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? No Yes # drinks/week _____
Is your alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreational drugs? No Yes
Have you ever used needles to inject drugs? No Yes

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 any sexually transmitted diseases (STDs)?
 No Yes
Are you interested in being screened for sexually transmitted
diseases? No Yes

Other Concerns

CAFFEINE Intake: None Coffee/tea/soda _____ cups/day

WEIGHT: Are you satisfied with your weight? No Yes

DIET: How do you rate your diet? Good Fair Poor

Do you eat or drink 4 servings of dairy or soy daily or take
calcium supplements? No Yes

EXERCISE: Do you exercise regularly? No Yes

What kind of exercise? _____

How long (minutes) _____ How often? _____

If you do not exercise, why? _____

SAFETY: Do you use a bike helmet? No Yes NA

Do you use seatbelts consistently? No Yes

Is VIOLENCE at home a concern for you? No Yes

Have you ever been ABUSED? No Yes

Do you have a GUN in your home? No Yes

SOCIOECONOMICS Occupation: _____ Employer: _____

Years of education/highest degree: _____ Marital Status: Single Partner/Married Divorced Widowed Other: _____

Spouse/partner's name: _____ Number of children/ages: _____

Who lives at home with you? _____

WOMEN'S HEALTH HISTORY: # pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____

1st day of most recent period: _____