Adult Medical Health History Form

This form will help your clinician better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Please provide your best guess when a date is requested.

Name: _____Date of Birth: _____Today's Date: _____
Preferred Provider: _____ Preferred Pharmacy: _____

MEDICATIONS *(Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, oxygen, CPAP)*

Medication and Dose	Instructions	Medication and Dose	Instructions

ALLERGIES *(Medicines, Seasonal, Environmental, Foods)*

Allergy	Reaction	Allergy	Reaction

PERSONAL MEDICAL HISTORY

Please make a check mark next to any medical problem you have ever had and list the date of diagnosis.

Condition	Yes	Condition	Yes
Heart Attack		Depression	
High Blood Pressure		Anxiety	
Diabetes		Suicide Attempt	
High Cholesterol		Alcohol Abuse	
Stroke		Substance Abuse	
Bleeding/Clotting Disorder		Other*	
Thyroid Problem, *please specify type*		Cancer, *please specify type*	

*Other problems, *please specify*_____
If you have ever had a blood transfusion, please specify date(s) _____
Would a blood transfusion be acceptable in an emergency? ____No ____Yes
Do you have any religious or spiritual beliefs? ____No ____Yes
Do you have any advanced health care directives? _____No ____ Yes
Last Dental Exam? _____ Last Eye Exam? _____ Last Podiatry Exam? _____

Surgical History	Date

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FAMILY HISTORY *Please list any biological family members that have ever had any of the following conditions.*

Condition	Family Member	Condition	Family Member
Alcoholism/Substance Abuse		COPD	
Anemia		Heart disease/Heart attack	
Anxiety		Heart Failure	
Arthritis		Heart Valve problems	
Asthma		High blood pressure	
Bipolar Disorder		High cholesterol	
Birth defects		Kidney disease	
Cancer (type)		Liver disease	
Depression		Osteoporosis	
Diabetes (type)		Stroke	
Seizures		Thyroid disorder	
Glaucoma		Other	

SOCIAL HISTORY

Tobacco Use

____ Never _____ Quit Date

Current Smoker: ____packs/day _____ # of years

Other: ____ Pipe _____ Cigar _____ Snuff _____ Chew _____ E-cigarettes/Vape

Are you interested in quitting? _____ No _____ Yes

Alcohol Use

Do you drink alcohol? _____ No _____ Yes, # drinks/week_____

Is alcohol use a concern for you or others? _____ No _____ Yes

Drug Use

Do you use any street drugs? ____ No ____ Yes, *please specify:* _____

Have you ever used street drugs? ____ No ____ Yes, *please specify:* _____

Have you ever injected street drugs? _____ No _____ Yes, *please specify:* _____

Diet/Exercise

meat servings per day: _____ # fresh fruit/vegetable servings per day: _____

of snacks per day: _____ # sweetened beverages per day: ____ # caffeinated beverages per day: _____

Do you exercise regularly? _____ No _____ Yes, *please specify*: _____

SOCIOECONOMICS

Are you currently employed? ____ No _____ Yes Occupation: _____

Education completed: __ Grade school __ High school __ 2-year College __ 4-year College __ Post-Graduate

Marital status: ____Single ____M ____Sep ____D ____W ____Cohabitating

Spouse/Partner's name: _____

Number of children: _____

Who lives at home with you? _____

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WOMEN'S GYNECOLOGIC HISTORY

pregnancies: ____ # deliveries: ____ # miscarriages: ____ # abortions: _____ Age at first childbirth: ____
1st day, most recent period: _____ Age at 1st period: ____ Frequency of periods: _____
Length of each period: _____
Do you have any concerns about your periods? ___ No ___ Yes: _____
Ever had an abnormal PAP? ____ No ___ Yes: results _____
Do you have any concerns about menopause? ___ No ___ Yes: _____

SEXUALITY

Sexually Active: ____ Yes ____ No ____ Not currently
Current sex partner(s) is/are: ___ male ___ female
Birth Control method: _____ _____ None needed
If sexually active, do you practice safe sex (use condoms)? _____ NA ____ No _____ Yes
Have you ever had any sexually transmitted diseases (STDs)? ____ No ____ Yes
If yes, please specify: _____date_____
Are you interested in being screened for sexually transmitted diseases? ____ No ____ Yes
Ever been exposed to HIV/AIDS? _____ No _____ Yes
Have you been tested for HIV? _____ No _____Yes: results _____
Would you like to be tested for HIV? _____ No _____ Yes
Other concerns? _____

SAFETY

Do you have a gun in your home? ____ No ____ Yes
Do you have a smoke detector in your home? ___ No ___ Yes
Do use seatbelts consistently? ___ No ___ Yes
Do you use sunscreen regularly? ____ No ____ Yes
Is violence at home a concern for you? ____ No ____ Yes
Do you feel safe in your current relationship? ____ N/A ____ No ____ Yes
Other concerns? _____

EMOTIONS

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
____ No ____ Yes
During the past month, have you often been bothered by little interest or pleasure in doing things?
____ No ____ Yes

HEALTH MAINTENANCE

Please enter the date of your most recent immunizations and tests.

Flu _____ Pneumonia _____ Shingles _____ Tetanus _____ HPV _____
Hepatitis A _____ Hepatitis B _____ Measles _____ Mumps_____ Rubella_____
MMR _____ Varicella (chicken pox) _____ PPD _____
PAP _____ Mammogram _____ Bone Density study _____ Colonoscopy _____ EKG _____

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REVIEW OF SYSTEMS

Please make a check mark next to any symptoms you have had in the last couple of days:

Constitutional		**Respiratory**	
Unintended Weight Loss		Cough	
Unintended Weight Gain		Shortness of breath or difficulty breathing	
Poor Appetite		Wheezing	
Fever		Coughing up sputum	
Chills		Coughing up blood	
No Energy		Chest tightness	
Eyes		**Gastrointestinal**	
Pain		Difficulty swallowing	
Blurry vision		Abdominal pain	
Double Vision		Heartburn	
Redness		Nausea	
Itchiness		Vomiting	
Swelling		Diarrhea	
Discharge		Blood in stool	
Ears, Nose, Throat		Mucus in stool	
Ear Pain		Change in bowel habits	
Discharge		Loss of bowel control	
Hearing Loss		**Genitourinary**	
Ringing in the ears		Discharge	
Sinus Pressure		Blood in urine	
Drooling		Pain with urination	
Facial Swelling		Increased frequency or urgency	
Sore Throat		Urinary loss of control	
Mouth Lesions		Flank pain	
Dental Pain		Testicular pain or swelling	
Swollen Glands		Redness	
Cardiovascular		Itchiness	
Swelling		Masses/lumps	
Chest Pain		**Musculoskeletal**	
Shortness of breath with activity		Soft tissue swelling	
Heart Palpitations (heart racing or fluttering)		Muscle pain	
Breasts		Moves arms and legs well	
Lumps		Localized joint pain	
Tenderness		Previous injuries	
Discharge		Spine pain	
		Pain radiating down arms	
		Pain radiating down legs	
		Weakness in arms	
		Weakness in legs	

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Skin		**Female Health**	
Pain		Irregular Menses	
Itching		Non-menstrual Bleeding	
Dryness/Flaking		Menopausal Symptoms	
Redness		Hot Flashes	
Rash/Hives		Night Sweats	
Growths/Lumps		Dry Vaginal Mucosa	
Swelling		Change in Libido (sex drive)	
Bruising		Orgasmic Dysfunction	
Insect Bites		Difficult or Painful Intercourse	
Lesions		Vaginal Tightening	
Neuro		**Male Health**	
Numbness		Change in Libido	
Weakness		Difficulty with Intercourse	
Tingling		Impotence	
Burning		**Allergic/Immunologic**	
Shooting Pain		Seasonal Allergies	
Headache		Sneezing	
Dizziness		Runny Nose	
Trouble finding words or forgetting words		Food Allergy	
Speech Difficulties		Contact Dermatitis (allergic skin rash)	
Poor Coordination			
Loss of Consciousness			
Arm or hand weakness			
Difficulty Emptying Bladder			
Change in Bowel Habits			
Psychiatric			
Decreased Functioning Ability			
Depression			
Anxiety			
Insomnia			
Stress			
Loss of Interest			

Please feel free to make any additional comments for any symptoms you are experiencing or any concerns you may have and would like to discuss at your initial appointment:

_____
_____
_____
_____
_____