PATIENT NAME: ____

ADULT MEDICAL HISTORY FORM

Please complete all pages

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you!

PRESENT HEALTH CONCERNS *(Please give a brief description of your current health concerns)*

____
____
____
____
____
____
____

PERSONAL MEDICAL HISTORY *(Please indicate YES or NO to each condition)*

Condition	*YES*	*NO*	Condition	*YES*	*NO*
Congenital heart defect	☐	☐	Alcoholism	☐	☐
If yes, what type? ____________			Abnormal PAP smear	☐	☐
Myocardial infarction (heart attack)	☐	☐	History of tick bite	☐	☐
Hypertension (high blood pressure)	☐	☐	Coagulation (bleeding/clot)	☐	☐
Diabetes	☐	☐	Cancer (malignancy)	☐	☐
High cholesterol	☐	☐	If yes, what type? ____________		
Stroke	☐	☐	Depression / suicide attempt	☐	☐
History of lice	☐	☐	Have you ever had a blood transfusion?	☐	☐
Thyroid problem	☐	☐	If yes, when? ____________		
If yes, what type? ____________					

Other problems:

____
____

SURGICAL HISTORY *(Please list all prior operations and dates)*

OPERATION	**DATE**

PATIENT NAME: ____

WOMEN'S GYNECOLOGIC HISTORY

Number of pregnancies ________________________________
Number of deliveries ________________________________
Number of miscarriages ________________________________
First day of most recent period ________________________________
Age at first period ________________________________
Frequency of periods ________________________________
Length of periods ________________________________
Do you have any concerns about your periods? ________________________________
Do you have any concerns about menopause? ________________________________

IMMUNIZATIONS *(Please list your most recent immunizations. Please include your best estimate of the month and year of each immunization.)*

Immunization	Month	Year
Hepatitis A		
Hepatitis B		
Tetanus (Td)		
Measles		
Mumps		
Rubella		
MMR		
Varicella (chicken pox)		
Pneumovax 23		
Prevnar 13		
Influenza		
Other		

PATIENT NAME: ____

FAMILY HISTORY ***(Please indicate with a check mark (√) family members who have had any of the following conditions. If yes, please explain in the space below.)***

Medical Condition	Self	Mom	Dad	Sibling	Children
Alcoholism					
Anemia					
Anesthesia problem					
Asthma					
Birth Defects					
Bleeding problem					
Cancer, Breast					
Cancer, Colon					
Cancer, Melanoma					
Cancer, Skin (non-melanoma)					
Cancer, Ovary					
Cancer, Prostate					
Cancer (not noted)					
Depression					
Diabetes, Type 1					
Diabetes, Type 2					
Eczema					
Epilepsy (seizures)					
Genetic Disease					
Glaucoma					
Hay Fever (allergic rhinitis)					
Hearing Problems					
Heart Attack					
High Blood Pressure					
High Cholesterol					
Kidney Diseases					
Lupus					
Mental Retardation					
Migraine Headaches					
Mitral Valve Prolapse					
Osteoarthritis					
Osteoporosis					
Rheumatoid Arthritis					
Stroke					
Thyroid disorders					
Tuberculosis					
Other					

Explanation:

____

____

____

If either of your parents is deceased, please indicate at what age they died.

____

____

PATIENT NAME: ____

SOCIAL HISTORY

TRAVEL

YES / NO

Where were you born? ______________________

What is your occupation? ______________________

Have you travelled domestically (within the U.S.)? ☐ ☐

Please list all the states you have visited: ______________________

Have you travelled internationally? ☐ ☐

Please list all of the countries you have visited: ______________________

SUBSTANCES

YES / NO

Have you ever used tobacco / cigarettes? ☐ ☐

If you quit, please provide date: ______________________

Packs per day: ______________________

Number of years you have smoked: ______________________

Do you drink alcohol? ☐ ☐

How many drinks per week? ______________________

Is alcohol use a concern for you or for others? ☐ ☐

Do you use any recreational drugs? ☐ ☐

Have you ever used needles? ☐ ☐

PETS

YES / NO

Do you have any pets? If yes, please list: ______________________ ☐ ☐

SAFETY

YES / NO

Is violence at home a concern for you? ☐ ☐

Do you feel safe in your current relationship? ☐ ☐

SEXUALITY

YES / NO

Are you sexually active? ☐ ☐

Current sex partner(s) is/are: ☐ Male ☐ Female

Birth control method: ______________________

If sexually active, do you practice safe sex? ☐ ☐

Have you ever had any sexually transmitted diseases (STDs)? ☐ ☐

If yes, please list and provide date: ______________________

EXERCISE

YES / NO

Do you exercise regularly? ☐ ☐

PATIENT NAME: ____

OUTDOOR ACTIVITIES

	YES	*NO*
Do you camp, hike, or do other outdoor activities?	☐	☐
If yes, please explain: ______________________		
Have you ever had exposure to mice or rats? (As pets, rodents in your home, etc.)	☐	☐

EMOTIONS

	YES	*NO*
In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?	☐	☐
Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?	☐	☐
Have you felt depressed or sad much of the time in the past year?	☐	☐

PATIENT NAME: ____

MEDICATION FLOW SHEET

Allergies:	Pharmacy:
	Location:
	Phone:

PRESCIPTION MEDICATIONS	DOSAGE	HOW OFTEN DO YOU TAKE IT?
OVER THE COUNTER MEDICATIONS / SUPPLEMENTS	DOSAGE	HOW OFTEN DO YOU TAKE IT?

PATIENT NAME: ____

REVIEW OF SYMPTOMS which you are currently experiencing. Please indicate either YES or NO by placing a check (√) in the boxes provided.

YES / NO		**Constitutional**
☐	☐	Recent fever
☐	☐	Night sweats
☐	☐	Recent weight loss > 10 lbs
☐	☐	Recent weight gain > 10 lbs
☐	☐	Fatigue
☐	☐	Chills

YES / NO		**Eyes**
☐	☐	Contact lenses
☐	☐	Yellowing of the eyes
☐	☐	Vision changes
☐	☐	Loss of vision

YES / NO		**Ears/Nose/Throat**
☐	☐	Hearing loss
☐	☐	Blood in sputum
☐	☐	Tooth abscess
☐	☐	Ringing in the ears
☐	☐	Choking while swallowing
☐	☐	Food gets stuck while swallowing
☐	☐	Nose bleeds

YES / NO		**Cardiovascular**
☐	☐	Chest pains
☐	☐	Palpitations
☐	☐	Swollen ankles or feet

YES / NO		**Respiratory**
☐	☐	Productive cough
☐	☐	Sleep apnea CPAP or BiPAP Yes ☐ No ☐
☐	☐	Chronic cough
☐	☐	Shortness of breath

YES / NO		**Genitourinary**
☐	☐	Painful urination
☐	☐	Difficulty urinating
☐	☐	Pregnant
☐	☐	Blood in urine
☐	☐	Loss in force stream
☐	☐	Recurrent urinary tract infections

YES / NO		**Musculoskeletal**
☐	☐	Back pain
☐	☐	Difficulty walking
☐	☐	Joint pain or arthritis
☐	☐	Muscle weakness/pain

YES / NO		**Skin**
☐	☐	Recent change in mole or birthmark
☐	☐	Breast mass, discharge, skin dimpling
☐	☐	Non-healing wounds
☐	☐	Skin rash or eruption
☐	☐	Heat/cold intolerance

YES / NO		**Neurological**
☐	☐	Weakness of one arm or leg
☐	☐	Frequent headaches
☐	☐	Fainting or blackouts
☐	☐	Memory loss
☐	☐	Confusion
☐	☐	Fall in last 3 mos?
☐	☐	Tremors
☐	☐	Dizziness

YES / NO		**Blood/lymphatic**
☐	☐	Excessive bleeding
☐	☐	Easy bruising

PATIENT NAME: ____

YES	*NO*	**Gastrointestinal**
☐	☐	Abdominal pain
☐	☐	Acid reflux
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Black or tarry stools
☐	☐	Constipation

YES	*NO*	**Psychiatric**
☐	☐	Serious depression
☐	☐	Panic attacks
☐	☐	Sleep disturbance
☐	☐	Nervousness