ADULT MEDICAL HISTORY

Your answers on this form will help us understand your medical concerns and conditions better. All information will be kept confidential.

Name _____ Date of Birth _____/_____/_____
Last First MI

Address _____ Age _____ Sex: M F T
Street Apt City Zip

Home ( ) _____ Cell ( )_____ Work ( )_____

E-Mail_____ Occupation _____

The person we call when we schedule appointments : Name_____ Phone ( ) _____

EMERGENCY CONTACT

Name _____ Relationship _____

Address _____

Home ( ) _____ Cell ( )_____ Work ( )_____

ILLNESS AND MEDICAL PROBLEMS

If you are not certain of when an illness started, write down an approximate year.

ILLNESS	YEAR	ILLNESS	YEAR	ILLNESS	YEAR
Eye or eye lid infection	_____	Heart murmur	_____	Migraine headache	_____
Glaucoma	_____	Other heart condition	_____	Epilepsy/Seizures	_____
Other eye problems	_____	Stomach/duodenal ulcer	_____	Head injury	_____
Deafness	_____	Diverticulosis	_____	Stroke	_____
Bronchitis	_____	Colitis	_____	Arthritis	_____
Emphysema	_____	Gout	_____	Cancer	_____
Pneumonia	_____	Yellow jaundice	_____	Bleeding tendency	_____
Allergies or asthma	_____	Liver trouble	_____	Diabetes	_____
Tuberculosis	_____	Hepatitis	_____	Mental illness	_____
Other lung problems	_____	Hernia	_____	Depression	_____
High blood pressure	_____	Hemorrhoids	_____	Anxiety	_____
Heart attack	_____	Kidney or bladder disease	_____	Other (please indicate)	_____
High cholesterol	_____	Kidney stone	_____	_____	_____
Arteriosclerosis	_____	Prostate problem	_____	_____	_____

FAMILY HEALTH HISTORY

Relationship	Age if Living	Age at Death	Health conditions or cause of death
Father			
Mother			
Brother Sister			
Brother Sister			
Brother Sister			
Brother Sister			
Spouse Partner			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

MEDICATIONS

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS, VITAMINS, INHALERS, BIRTH CONTROL PILLS, SUPPLEMENTS

MEDICATION	Dose	Physician

LIST ALL YOUR <u>ALLERGIES</u> AND HOW THEY AFFECT YOU

Allergic to:	Reaction	Allergic to:	Reaction

WHO ARE YOUR CURRENT TREATING PHYSICIANS

List all physicians who have provided you care the last 5 years

NAME / REASON FOR CARE	ADDRESS	PHONE / FAX

PLEASE LIST PREVIOUS HOSPITALIZATIONS

YEAR	REASON	HOSPITAL	CITY AND STATE

SOCIAL / PERSONAL HISTORY

Currently Live: ☐ Alone ☐ With family ☐ With friend(s) ☐ With significant other

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Partnered ☐ Widowed

Have you ever been rejected for health reasons by the military, an employer, or an insurance company? ☐ No ☐ Yes

If yes, please explain:_____

Smoking history: Do you currently smoke: ☐ No ☐ Yes How much per day:_____ How many years?_____

Are you a former smoker? ☐ No ☐ Yes Do you chew tobacco? ☐ No ☐ Yes

Consumption of alcoholic beverages: ☐ No ☐ Yes, if so how much_____

Do you use drugs? ☐ No ☐ Yes, if so Type_____Frequency_____

Do you exercise regularly? ☐ No ☐ Yes, if so how often_____Do you wear seatbelts? No☐ Ye☐

Are there any health risks involved in your job, home environments, or activities? ☐ No ☐ Yes, if so please explain: