Adult Medical History

Patient Name: ______________________ **DOB:** __________ **M:** _____ **F:** _____

Allergies: ____

Original date of completion: ___________ **Updated:** _________ **Updated:** _________ **Updated:** _________

Past Medical History & Review of Systems: *Please indicate (✓) if you have had problems with or presently have complaints of any of the following:*

Symptom / Complaint		Symptom / Complaint		Symptom / Complaint		Symptom / Complaint	
High Blood Pressure		Persistent cough		Hemorrhoids		Sin disease	
Diabetes		TB		Gall bladder disease		Blood disorder	
Cancer		Hay fever		Colitis		Venereal disease	
Heart Disease		Abdominal pain		Hepatitis / liver disease		Anxiety	
Chest pain / tightness		Indigestion		Thyroid disease		Depression	
Shortness of breath		Nausea		Head or neck radiation		Anemia	
Swollen ankles		Vomiting		Headache		Alcohol abuse	
Palpitations		Constipation		Kidney disease		Drug abuse	
Lightheadedness		Diarrhea		Kidney stones		Tobacco use	
Rheumatic Fever		Blood in stool		Difficult urination		Gout	
Asthma		Ulcers		Frequent urination		Chicken pox	
Bronchitis		Change in bowel habits		Arthritis		German measles	
Pneumonia		Unexplained weight loss		Low back problems			

Gynecologic and Obstetrical History:

OB/GYN provider: ______________________ LMP: ______________

Age at onset of periods ________ Frequency ________ Duration ________ # of pregnancies _____ # of Births _____ # of miscarriages ________

Complication of pregnancies ______________________________________

Contraceptive plan ______________ Last PAP ____________ Last Mammogram ____________

Do you have? Prolonged or abnormal bleeding ________ Leakage of urine ________ Pelvic pain ________ Abnormal bleeding ________

History of abnormal bleeding ______________ other: ______________________

Surgical History:

Surgery	Date	Location

Family History: *Please indicate (✓) if any family member has had or currently is experiencing any of the following:*

Diabetes		Heart disease		Elevated triglycerides		TB	
Cancer		Stroke		Mental retardation		Sickle cell anemia	
Convulsions		High blood pressure		Sudden infant death		Eye problems	
Allergies		Elevated Lipids		Alcohol addiction		Dental problems	
Asthma		Elevated Cholesterol		Drug addiction		Eczema / skin problems	
Kidney disease		Elevated HDL		Tobacco use		Emotional disorder	
Blood disorders		Elevated LDL		Migraines		Other:	

Prevention Screening: *Please indicate (✓) Yes or No to the following questions:*

	YES	NO		YES	NO
Do you use alcohol/tobacco/drugs or other substances?			Are you at risk for AIDS?		
Do you wear a seatbelt?			Do you wish to be tested for AIDS?		
Do you wear a bike helmet?			Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?		
Do you have guns in your home?			Do you ever feel afraid of your partner?		
Do you have a living will?			Are you in a relationship in which you have been physically hurt (eg., slapped, kicked, punched, bruised)?		
Do you have an organ donor card ?			Do you perform self breast examination?		

Current Medications:

Medication	Start date	Ordered by (Provider name)