

Adult Medical History Form

*****Please Complete Both Sides**

Patient Name: _____

Date of Appointment: _____

Date of Birth: _____

What issues would you like to be addressed at your appointment?

Past Medical History (include date of onset)

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Lupus
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Recurrent Infections
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Gout	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Headache	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bowel Obstruction	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Hernia	
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> HIV	
<input type="checkbox"/> COPD/Emphysema	<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Colitis/Crohn's	<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> High Triglycerides	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Insomnia	
<input type="checkbox"/> Dementia	<input type="checkbox"/> Kidney Failure	
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Stones	

Details: _____

Females Only:

Age of first menses: _____

Date of last menstrual period: _____

Age at menopause: _____

Are you sexually active? _____

of pregnancies: _____

Method of contraception: _____

Past Surgical History (include dates, facility)

Previous Physicians and Specialists

Medications (include dose and frequency)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Herbs, Supplements and Vitamins

Family History

	Age	Living or Deceased?	Medical Issues
Mother			
Father			
Siblings			
Children			

Social History

Single Married Divorced Widowed

	Type	Quantity Daily	Years of Use	Ever Tried to Quit?	Methods Used
Tobacco					
Alcohol					
Drugs					

Occupation: _____

Exercise: _____

Preventive Care

Test	Baseline EKG	Colon Cancer Screening	Skin Exam	Lipid Panel	PSA	Blood Sugar	Eye Exam	Pap Smear	Mammo-gram	Bone Density
Date										
Where?										
Results										

Patient Signature _____

Date _____

Reviewed by a Physician _____