Please complete both sides.

Adult History

Name ____________________ Date ____________

Date of Birth ____________ Age ______ Marital Status ❑S ❑M ❑D ❑W

Occupation ____________________ Years of Education ________

List all Medications you now take. Include prescribed, over-the-counter, vitamins, drops and topicals.

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________
7. ____________
8. ____________

List Medications to which you are allergic/type of reaction

1. ____________
2. ____________
3. ____________
4. ____________

Any other allergies or sensitivities:

Operations/approximate dates:

Other hospitalizations or major injuries/approximate dates:

Serious illness not requiring hospitalization, or chronic illness:

Health Review: Mark the ones that *best* describe you:

Tobacco: ❑ None ❑ Pipe/Cigar ❑ Chew ❑ Cigarettes Amount Daily______ How Long?______ ❑ Quit?

Alcohol: ❑ 1/week- 2/day ❑ Weekends ❑ None ❑ Over 2 Drinks Daily ❑ Quit?

Coffee: ❑ 0-4 Cups Daily ❑ More:______

Meals: ❑ Regular Low-fat ❑ Regular ❑ Often skip ❑ Fast Food

Exercise: ❑ Regular ❑ Occasionally ❑ Rarely ❑ No

Use of seat belts ❑ Yes ❑ Occasionally ❑ Rarely ❑ No

Use of street drugs ❑ No ❑ Yes Details: Last Tetanus Shot date:_________

Family History	Age	Check if Deceased	Alcoholism	Arthritis	Asthma	Bleeds Easily	Cancer	Diabetes	Epilepsy	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Mental Illness	Migrane	Stroke	TB	Thyroid Disease	Other
Father																			
Mother																			
Bro/Sis																			
Bro/Sis																			
Spouse																			
child																			
child																			
child																			

Have you had the following symptoms or problems either in the past or now? Please check the appropriate boxes.

General
Current Past
- ❑ ❑ Anemia
- ❑ ❑ Unexplained weight gain
- ❑ ❑ Unexplained fatigue or weakness
- ❑ ❑ Thyroid problems
- ❑ ❑ Diabetes or high blood sugar
- ❑ ❑ Fever or chills
- ❑ ❑ Unusual lymph glands
- ❑ ❑ Cancer
- ❑ ❑ Rashes
- ❑ ❑ Risk Factors for AIDS
- ❑ ❑ Sleep difficulties
- ❑ ❑ None of the above

Head
Current Past
- ❑ ❑ Migraine
- ❑ ❑ Frequent, severe or unusual headaches
- ❑ ❑ Change in vision
- ❑ ❑ Wear glasses/contacts
- ❑ ❑ Glaucoma
- ❑ ❑ Hearing difficulty
- ❑ ❑ Nosebleeds
- ❑ ❑ Sinus problems
- ❑ ❑ Hair loss
- ❑ ❑ Dentures/bridge
- ❑ ❑ Bleeding gums
- ❑ ❑ Persistent hoarseness
- ❑ ❑ Difficulty swallowing
- ❑ ❑ Hay fever
- ❑ ❑ None of the above

Lungs
Current Past
- ❑ ❑ Shortness of breath
- ❑ ❑ Asthma or emphysema
- ❑ ❑ Frequent cough
- ❑ ❑ Coughing up blood or phlegm
- ❑ ❑ Tuberculosis
- ❑ ❑ Recurrent pneumonia or bronchitis
- ❑ ❑ Wheezing
- ❑ ❑ None of the above

Heart
Current Past
- ❑ ❑ Heart murmer
- ❑ ❑ Heart failure
- ❑ ❑ Waking up at night due to shortness of breath
- ❑ ❑ High blood pressure
- ❑ ❑ Rheumatic fever
- ❑ ❑ Chest pain, pressure, discomfort
- ❑ ❑ Heart attack
- ❑ ❑ Irregular heartbeat
- ❑ ❑ Swelling in the legs
- ❑ ❑ Calf pain
- ❑ ❑ Racing Heart
- ❑ ❑ Blood transfusion
- ❑ ❑ Easy bruising or bleeding
- ❑ ❑ None of the above

Please complete both sides.

Gastrointestinal
Current Past
- ❑ ❑ Indigestion or heartburn
- ❑ ❑ Ulcer
- ❑ ❑ Unexplained abdominal pain
- ❑ ❑ Vomiting or bleeding
- ❑ ❑ Hepititis or liver problems
- ❑ ❑ Frequent diarrhea
- ❑ ❑ Constipation
- ❑ ❑ Hemorrhoids
- ❑ ❑ Rectal bleeding
- ❑ ❑ Black tarry bowel movements
- ❑ ❑ Change in bowel movements
- ❑ ❑ None of the above

Urinary
Current Past
- ❑ ❑ Bladder or kidney infection
- ❑ ❑ Kidney stones
- ❑ ❑ Kidney disease
- ❑ ❑ Burning with urination
- ❑ ❑ Slow urine flow
- ❑ ❑ Difficulty starting or controlling urine stream
- ❑ ❑ Blood in urine
- ❑ ❑ Venereal disease
- ❑ ❑ Sexual problems
- ❑ ❑ None of the above

Men Only
Current Past
- ❑ ❑ Prostate problems
- ❑ ❑ Discharge from penis
- ❑ ❑ Lump in testicles
- ❑ ❑ Erectile dysfunction
- ❑ ❑ None of the above

Women Only
Current Past
- ❑ ❑ Breast lump
- ❑ ❑ Discharge from nipple
- ❑ ❑ Irregular periods
- ❑ ❑ Abnormal vaginal bleeding or spotting
- ❑ ❑ Abnormal PAP test

Last Pap Date:_____
Age at onset of periods______
Cycle:_______ Days (from start to start)
Birth control method __________
Number of pregnancies ________
Number of children ___________
Number of living children ______
Number of adopted children ____
None of the above ___________

Bone/Joints/Muscles
Current Past
- ❑ ❑ Painful or swollen joints
- ❑ ❑ Persistent back or neck pain
- ❑ ❑ Muscle cramps
- ❑ ❑ Osteoporosis
- ❑ ❑ None of the above

Psychological
Current Past
- ❑ ❑ Suicidal thoughts
- ❑ ❑ Suicide attempt
- ❑ ❑ Anxiety
- ❑ ❑ Depression
- ❑ ❑ Crying spells
- ❑ ❑ Memory problems
- ❑ ❑ Sleep problems
- ❑ ❑ Job or family difficulty
- ❑ ❑ Loss of interest in previously enjoyable activities
- ❑ ❑ None of the above

Neurological
Current Past
- ❑ ❑ Seizure or epilepsy
- ❑ ❑ Stroke
- ❑ ❑ Numbness of face, arm or leg
- ❑ ❑ Weakness of face, arm or leg
- ❑ ❑ Difficulty with speech
- ❑ ❑ Fainting or loss of consciousness
- ❑ ❑ None of the above

Other
Current Past
- ❑ ❑ Have you seen a specialist?

Do you feel well?_________
Do you have anything else to add to your medical history?
____
____
____
____
____
____
____