Adult Medical History Form

Name: ______________________________ Birthdate: __________ Today's Date: ___________
Please list your Medication **Allergies**: ____

____

Please list your current prescription **medicine**, over-the-counter medications, vitamins, supplements, and herbal products you take regularly (you may use the back of page 3 if needed)

Medication/Supplement Name	Dose	How often	Reason for Medication/ supplement

Health History – Please check if appropriate and indicate how many years present

Years present **Condition**

- ☐ ___________ Arthritis ____
- ☐ ___________ Asthma ____
- ☐ ___________ Cancer (type: ____)
- ☐ ___________ Diabetes ____
- ☐ ___________ Emphysema/COPD ____
- ☐ ___________ Gastrointestinal Problems ____
- ☐ ___________ Heart problems (type: ____)
- ☐ ___________ Kidney problems ____
- ☐ ___________ Liver problems or hepatitis ____
- ☐ ___________ Mental health problems ____
- ☐ ___________ Migraines ____
- ☐ ___________ Osteoporosis (weak bones) Fracture of hip or spine? ☐ yes ☐ no
- ☐ ___________ Sexually Transmitted Disease ____
- ☐ ___________ Thyroid problems ____
- ☐ ___________ Other: ____

Name ____ DOB ___________________________

Hospitalizations (include C-sections)

Year	Operation or Illness	Hospital	Doctor

Women's Health

No. of pregnancies ____ No. of miscarriages/abortions ____/____ No. of living children ______

Age you periods began _____ Date of last period _______ How often do periods occur ________

Are you sexually active? ____ Method of pregnancy prevention___________________________

Date of last mammogram (age 40+): ________ Results: ☐ Normal ☐ Other: _________________

Date of last PAP smear: ________ Results: ☐ Normal ☐ Other: _________________

Family History if Illness (please list close relative and age of diagnosis or death if known) Asthma: ____

Cancer: ____

Diabetes: ____

Heart Disease: ____

High Blood Pressure: ____

Mental Health: ____

Other: ____

Family Deaths at an early age (under 60): ____

Social History

Marital status: __________ Education (highest level): ___________ Occupation: ____________

How many children do you have? _______ How many brothers/sisters? _____ / _____

Do you smoke? ☐ yes ☐ no ☐ former ____ packs per day ____ years smoked ____ years quit

Do you chew tobacco? ☐ yes ☐ no ☐ former Do you have any toxic work exposures: † no † yes

Do you drink alcohol? ☐ yes ☐ no ☐ former ___ average drinks per week ___Max. drinks a day

Do you use marijuana, cocaine or similar drugs?: ☐ yes ☐no ☐ former

Have you traveled outside of the U.S. in the last 6 months:† no† yes: ______________________

How would you describe your diet? _________ How often do you exercise? _____ days per week

Prevention (please answer the questions to the best of your ability):

Date of last flu shot __________ Date of Shingles shot (over 60) ____________

Date of last pneumonia shot __________ Dates of HPV shots (women 9-26+) _________

Date of last tetanus shot __________ Dates of Hepatitis B shots: ________________

Have you ever had Chickenpox or the chickenpox vaccine? ☐ yes ☐ no ☐ unsure

Date of last cholesterol check _______ Results: ☐ Normal ☐ Borderline ☐ High ☐ Unknown

Date of last colon cancer screening (age 50+): _________ Type of screening: _____________

Date of last glaucoma screen (age 65+, 50+ for African American): _____________

Do you have a living will or power of attorney for healthcare? ☐ yes ☐ no

Would you like information on living wills or power of attorney? ☐ yes ☐ no

Name of person completing this form: _________________________________

Reviewed by healthcare provider (Initials and date): _______ ____ /____ / _____