Medical Adult Health History

To meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history.

Name: (Last) _____ (First) _____ (Middle) _____

Date of Birth: _____ Age: _____

Height: _____ ft. _____ in. Weight: _____ lbs. (Staff Use: T _____ RR _____ P _____ BP _____ / _____)

Past Medical History – Have you ever had the following: ____ Patient denies any past illness

	Condition	Dates		Condition	Dates		Condition	Dates
	AIDS			Epilepsy			Pneumonia	
	Alcohol			Glaucoma			Prostate Cancer	
	Alzheimer's			Heart Disease			Sickle Cell Anemia	
	Anemia			Hyper Cholesterol			Stroke	
	Arthritis			Hypertension			Suicidal	
	Asthma			Hyperthyroidism			TIA	
	Birth Defects			Hypothyroidism			Tuberculosis	
	Bleeding Disorder			Irritable Bowel			Ulcer	
	Cancer			Kidney Disorder			Urinary Tract Infection	
	COPD			Liver Disorder			Any other disease	
	Depression			Lung Cancer			Any other disease	
	Diabetes			Migraine			Any other disease	

Past Surgical History – Have you ever had the following: ____ Patient denies any past surgeries

Please list all serious illnesses, operations, and other hospitalizations you have experienced and the dates these occurred

	Condition	Dates		Condition	Dates		Condition	Dates
	Appendix			Cosmetic			Hernia Repair	
	Back Surgery			C-Section			Hysterectomy	
	Breast Biopsy			D & C			Tubal Ligation	
	Cataract			Gallbladder			Tonsil/Adenoids	
	Other			Other			Other	

Medications – Please list all medication you are currently taking _____ Patient denies any medications

Current Medications	Dosage (mg)	How often per day

Allergies – Please list all food, medication, and environmental allergies _____ Patient denies any allergies

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Family History – Has any blood relative had any of the following: (Leave blank if uncertain)

Patient denies family history of: _____ Breast Cancer _____ Colon Cancer _____GYN Cancer

Condition	Relationship to you
Cancer Type:	
Diabetes Type:	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Kidney Problem	

Menstrual History

Age of 1st period: _____ # of days between period: _____ Total days on period: _____ Date of last period: _____

Flow: _____ Light _____ Medium _____ Heavy Do you tend to clot: YES NO

Method of birth control: _____ Menopause Status: _____ Age when menopause began:_____

Breakthrough Bleeding: YES NO Hormone Replacement Therapy: YES NO

Pregnancy History

Total number of pregnancies: _____ Full term pregnancies: _____ Premature Births: _____ Multiple births: _____

Terminated Pregnancies: _____ Miscarriages: _____ Ectopic pregnancies: _____ Living: _____

Social History

Tobacco: ____ Never ____Minimal ____YES (_____ packs/day x _____ years) _____ QUIT _____ Years ago (_____ packs/day x _____ years)

Alcohol: ____ Never ____Minimal ____ Less than 10 a week, ____ More than 10 a week, _____ QUIT _____ Years ago

Illicit Drugs: ____ Never ____Minimal ____ YES (_____ packs/day x _____ years) _____ QUIT _____ Years ago (_____ packs/day x _____ years)

Marital Status : ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

Education Level: ____ High School ____College ____ Post Graduate ____ Other

Occupation: _____ Military Service: _____

Signature: _____ Date: _____