ADULT PAST MEDICAL HISTORY

Patient Name:	DOB:

MEDICAL HISTORY

List all allergies (Foods, medications, environmental etc.):

Please answer all questions that apply to you:

Condition		
Anemia	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Bleeding disorder	☐ YES	☐ NO
Blood clots in leg or lung	☐ YES	☐ NO
Chronic bronchitis or emphysema	☐ YES	☐ NO
Congenital abnormalities	☐ YES	☐ NO
Congestive Heart Failure	☐ YES	☐ NO
Depression/Anxiety	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Drug and alcohol problem	☐ YES	☐ NO
Esophageal reflux	☐ YES	☐ NO
Heart disease	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
High cholesterol	☐ YES	☐ NO
HIV infection	☐ YES	☐ NO
Kidney disease	☐ YES	☐ NO
Liver, stomach, or bowel disorder	☐ YES	☐ NO
Migraine	☐ YES	☐ NO
Cancer (Location):		
Osteoporosis	☐ YES	☐ NO
Parkinson's	☐ YES	☐ NO
Seizure disorder	☐ YES	☐ NO
Sexual transmitted infections (Chlamydia, Gonorrhea, Syphilis, HPV)	☐ YES	☐ NO
Skin problems	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Thyroid disease	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO

Others not listed:

MEDICAL HISTORY

Are you presently taking medications to include prescription drugs, over the counter or herbal remedies? If YES, please list below what medications, strength and for what condition.

Please list the date you received any of the following preventive health items:

Date of the last colonoscopy: ____________

Date of last rectal exam: ____________

Date of last eye exam: ____________

Date of last dental exam: ____________

Date of last Tetanus/Tdap vaccine: ____________

Date of last flu vaccine: ____________

Date of last pneumovax: ____________

Date of last tuberculosis skin test (PPD): ____________

If PPD was positive did you complete treatment? ____________

Date of last chest X ray: ____________

Patient Name:	**DOB:**

FEMALE HISTORY	
Age of first period: ____	Results of most recent pap (normal/abnormal): ____
Age of first pregnancy: ____	Colposcopy: ____
Number of pregnancies: ____	Date of last breast exam: ____
Number of deliveries: ____	Date of last mammogram: ____
Number of abortions/miscarriages: ____	Results of mammogram (normal/abnormal): ____
Current birth control method: ____	Where was your last mammogram performed: ____
Date of last pap: ____	Where was the pap smear performed: ____
MALE HISTORY	
Sexual impotence: ____	Leakage of urine or difficulty starting urination: ____
Pain or lump in testicles____	
Please list below all surgeries, year and if any complications:	

SOCIAL HISTORY	
Complete all that apply:	
Education- Number of years completed: ____	Do you currently smoke cigarettes or pipe? ☐ YES ☐ NO
Are you currently a student? ☐ YES ☐ NO	Are you a previous smoker? ☐ YES ☐ NO
What is your occupation? ____	How many cigarettes per day? ____
Are you currently working full time/part time/not working? ____	How many years have you been smoking? ____
Caffeine intake How many cups of coffee do you consume in a day? ____	Do you chew tobacco? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO	Are you married, single, divorced, widowed?
What type of alcohol (Beer, wine, hard liquor)? ____	Are you sexually active? ☐ YES ☐ NO
How many drinks per week? ____	Do you have more than one sexual partner? ____
Do you consume drugs? ☐ YES ☐ NO	Do you exercise? ☐ YES ☐ NO
What type of drugs? ____	What type of exercise? ____

Patient Name:	DOB:

FAMILY HISTORY

Has any of your blood relatives (Mother, Father, Brother, Sister, grandparents) had any of the following:

			RELATIONSHIP
Alcoholism	☐ YES	☐ NO	
Alzheimer's	☐ YES	☐ NO	
Autoimmune disease	☐ YES	☐ NO	
Bleeding problems	☐ YES	☐ NO	
Cancer (specify type):	☐ YES	☐ NO	
Depression	☐ YES	☐ NO	
Diabetes	☐ YES	☐ NO	
Epilepsy/Seizure's	☐ YES	☐ NO	
Heart disease	☐ YES	☐ NO	
High cholesterol	☐ YES	☐ NO	
High blood pressure	☐ YES	☐ NO	
Hepatitis	☐ YES	☐ NO	
Thyroid disorders	☐ YES	☐ NO	
Stroke	☐ YES	☐ NO	

Others not listed:

ADVANCED DIRECTIVE

What is an advanced Directive? It is a generic term for a document that instructs others about your medical care should you be unable to make decisions on your own.

What is a health care proxy/health care agent or durable power of attorney? It is a family member or friend that will have legal authority to make health care decisions for you if you are no longer able to speak for your self.

What is a living will? They are specific written instructions for your future health care in the event of a situation in which you can no longer speak for your self. Examples of decisions covered in the living will are life sustaining medical treatment if you are terminally ill or permanently unconscious.

Do you have Advance Directives?	☐ YES	☐NO
Do you have a living will or health care instructions?	☐ YES	☐NO
Do you have medical orders for life sustaining treatment?	☐ YES	☐NO
Do you have a health care agent or health care proxy?	☐ YES	☐NO

If you have any of the above mentioned documents, please provide a copy to be included in your health record.

PATIENT'S SIGNATURE: ______________________________ Date: ____________

PROVIDER'S SIGNATURE: ______________________________ Date: ____________