ADULT MEDICAL HISTORY
(18 and up)

Patient Name:		**DOB:**	
Source of information: [ ] Self [ ] Spouse [ ] Family member [ ] Another person			
MEDICAL HISTORY			
List all allergies (Foods, medications, environmental etc.): _____			
Please answer all questions that apply to you:		High blood pressure	☐ YES
Asthma	☐ YES	High cholesterol	☐ YES
Blood clots in leg or lung	☐ YES	HIV infection/AIDS	☐ YES
Cancer (Location): _____		Kidney disease	☐ YES
Chronic bronchitis or emphysema	☐ YES	Liver, stomach, or bowel disorder	☐ YES
Congestive Heart Failure	☐ YES	Seizure disorder	☐ YES
Depression/Anxiety	☐ YES	Stroke	☐ YES
Diabetes	☐ YES	Thyroid disease	☐ YES
Heart disease	☐ YES	Tuberculosis	☐ YES
Hepatitis	☐ YES	Others not listed: _____	
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 last Tetanus/Tdap vaccine:	
Date of last colonoscopy:		Date of last tuberculosis skin test (PPD):	
Date of last Shingles vaccine:		If PPD was positive did you complete treatment?	
Date of last pneumovax:		Date of last chest X ray:	
FEMALE HISTORY			
Age of first menstrual period:		Date of last pap:	
Number of pregnancies:		Date of last mammogram:	
Number of deliveries:		Current birth control method:	
SURGICAL/HOSPITALIZATION HISTORY			
Please list all surgeries, date and if any complications/Also list recent hospitalizations and reason: _____			
SOCIAL HISTORY	Complete all that apply:		
Do you drink alcohol?	☐ YES ☐ NO	How many drinks per week?	
Do you consume drugs?	☐ YES ☐ NO	What type of drugs?	
Did you ever smoke?	☐ YES ☐ NO	How many cigarettes per day?	
How many years have you been smoking?		Are you sexually active?	☐ YES ☐ NO
FAMILY HISTORY: Have any of your blood relatives (Mother, Father, Brother, Sister, grandparents) had any of the following conditions?			
Bleeding problems:	☐ YES	Mental health illness	☐ YES
Cancer (specify type):	☐ YES	High blood pressure:	☐ YES
Diabetes:	☐ YES	Stroke:	☐ YES
Heart disease:	☐ YES	Substance abuse:	☐ YES
High cholesterol:	☐ YES	Other:	
Patient Signature: _____ **Date:** _____			