# ADULT MEDICAL HISTORY

Date:_____

_____

Last Name First Name Middle Name Date of Birth

__M_ F_____

Sex/ Gender Occupation Employer Social Security Number

_____

Home Address City State Zip Code Home Phone

_____

Work Address City State Zip Code Work Phone

_____

E-mail Address Cellular Phone Pharmacy Name | Phone

_____

Emergency Contact Name | Relationship | Phone

_____

Primary Medical Insurance Subscriber Name ID/Policy# Group#

_____

Secondary Medical Insurance Subscriber Name ID/Policy# Group#

**Can the physician or staff leave test result information (non-urgent) on your answering machine? ☐YES ☐NO**
**Can the physician or staff send test result information (non-urgent) to your e-mail address above? ☐YES ☐NO List anyone that you will allow us to release your medical information to:**_____

**ALLERGIES TO MEDICATIONS:** ☐None

**PAST/PRESENT MEDICAL PROBLEMS:**(Please Circle) ☐None

| | | | | |
|---|---|---|---|---|
| Anemia | Bleeding Problem | Emphysema | Hepatitis | Stomach Problem |
| Anxiety | Cancer | Gout | High Blood Pressure | Stroke |
| Arthritis | Depression | Hay Fever | High Cholesterol | Thyroid Problem |
| Asthma | Diabetes | Headaches | Kidney/Liver | Tuberculosis |
| Back/Neck Pain | Drug Abuse | Heart Problems | Seizures | Ulcers |

**Other:**_____

**SURGERIES/HOSPITALIZATIONS (Please include dates):** ☐None

_____

_____

**MEDICATIONS (Please include doses):** ☐None

_____

_____

**FAMILY HISTORY:**

**Has any member of your family (Grandparents, Parents , Siblings) ever had the following?**

| | YES | NO | Relationship | | YES | NO | Relationship |
|---|---|---|---|---|---|---|---|
| Asthma | | | | High Cholesterol | | | |
| Arthritis | | | | Kidney Disorder | | | |
| Blood Disorder | | | | Seizure | | | |
| Cancer | | | | Stomach Disorder | | | |
| Diabetes | | | | Stroke | | | |
| Drug Abuse | | | | Thyroid Disorder | | | |
| Heart Problems | | | | Tuberculosis | | | |
| High Blood Pressure | | | | Other: | | | |

## SOCIAL HISTORY:

Relationship Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐Other:_____

Education: ☐Grade School ☐High School ☐College Degree_____/ ☐Graduate Degree_____

Tobacco Use: ☐None ☐Current Use ☐Prior Use Year Started ____ Year Quit ____ Packs per day____

Alcohol Usage: ☐Never ☐Occasionally ☐Rarely ☐Weekly ☐Daily ☐Beer ☐Wine ☐Spirits
Number of drinks per day/ week: ____
Are you or others you know concerned about your use of alcohol? ☐YES ☐NO

Diet/ Exercise: Do you do aerobic exercise at least three times per week? ☐YES ☐NO
Do you eat at least three meals per day? ☐YES ☐NO
Do you feel that you need to gain/ lose weight? ☐YES ☐NO
Do you take nutritional supplements? ☐YES ☐NO List:

**GYNECOLOGIC HISTORY:**

Age at onset of periods: _____ Frequency: _____ Length of periods: _____
Pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____
Date of last PAP: _____ Date of last Mammogram: _____
Any abnormal bleeding? ☐YES ☐NO Any abnormal discharge? ☐YES ☐NO
Any leakage of urine? ☐YES ☐NO Ever had an abnormal PAP? ☐YES ☐NO
Any Pelvic pain? ☐YES ☐NO Are you going thru or finished Menopause? ☐YES ☐NO

## OTHER QUESTIONS OR CONCERNS:

_____ _____

**Patient's Signature** **Date**