Adult Patient History

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Occupation: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Race: _____ Age:_____

Past Medical History Have you ever had any of the following? (Check)

☐ High blood pressure	☐ Asthma	☐ Hepatitis	☐ Arthritis
☐ Heart attack/angina	☐ Tuberculosis	☐ Kidney disease/stone	☐ Stroke
☐ Heart murmur	☐ Phlebitis	☐ Stomach ulcers	☐ Migraine headaches
☐ Crohn's disease	☐ Bleeding disorder	☐ Diabetes	☐ Seizures
☐ Rheumatic fever	☐ Sickle cell anemia	☐ Thyroid disease	☐ Anxiety
☐ Pneumonia	☐ Blood transfusion	☐ Cancer	☐ Glaucoma
☐ Emphysema	☐ Gallstones	☐ Sexually transmitted disease	☐ Cataracts
☐ Prostate trouble	☐ High cholesterol	☐ Depression	☐ Trouble achieving and/or maintaining an erection
☐ HIV disease			

Other serious illnesses: _____

Operations (give date or age)

Tonsils _____ Gallbladder _____ Kidney _____ Biopsy _____

Appendix _____ Stomach _____ Hysterectomy _____ Prostate _____

Hernia _____ Heart _____ Ovaries removed _____ Breast _____

Other _____ Tubal ligation _____

Other Hospitalizations / Accidents / Injuries _____

Family History

	Age	Alive	Deceased	Health Problems
Father				
Mother				
Sister				
Sister				
Brother				
Brother				
Children				

Immunizations (approximate age or date) PPD_____ Flu_____

Pneumonia _____ Tetanus _____ Hepatitis _____

For Women

Age at first period _____ Date of last period _____ Age at menopause _____

Regular periods? ☐ Yes ☐ No Interval between periods _____ Length of periods _____

# of pregnancies _____ Live births _____ Miscarriages _____ Abortions _____ Stillbirths _____

Birth control method _____ Doing monthly self breast exam? _____

Allergies (medications, foods, pollens, etc.)

Current Medical or Psychological Problems

List all conditions currently being treated: Name of Physician:

Current Medications

(List name, dosage, times per day. Include non-prescription drugs, vitamins, laxatives, herbs, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Habits Do you:	Yes	No	Amount/Type
Use drugs (marijuana, cocaine)			
Use tobacco (cigarettes, cigars, chewing tobacco)			
Use alcohol (beer, wine, liquor)			
Use caffeine (coffee, tea, colas)			
Diet (restrictions, special diet)			
Exercise regularly			
Wear seat belts?			

When did you last have these performed?

Prostate exam _____ Breast exam _____ Rectal exam _____

EKG _____ Mammogram _____ Stool test for blood _____

Cholesterol _____ Pap Smear _____ Colon scope test _____

Have you ever been: on disability? _____

Denied life or health insurance? _____

Have you had a significant weight change in the last year? _____

Do you have a living will or advance directive? _____ If not, are you interested in information about this? _____

What are the most important medical problems you have now? _____

Patient Signature: _____ **Date:** _____ **Time:** _____

Reviewed by: _____ **Date:** _____ **Time:** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)