Northwest PRIMARY CARE

Adult Medical History Form

Legal Name: _____ DOB: _____ Date: _____

Preferred Name (if different than above): _____

Marital Status: S M W D Partner

Occupation: _____

If retired, previous occupation: _____

Household (who lives in your household?

List allergies/intolerances to medications (and the reaction they cause):

Personal Medical History: Circle Yes or No, explain yes answers (when occurred or was diagnosed)

Alcoholism	Y	N
Anxiety Disorder	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Bleeding tendency	Y	N
Blood clot	Y	N
Cholesterol (high)	Y	N
Cancer	Y	N
Depression	Y	N
Diabetes	Y	N
Emphysema/COPD	Y	N
Epilepsy	Y	N
Exposure to asbestos	Y	N
Exposure to TB	Y	N
Glaucoma	Y	N
Hayfever	Y	N
Heart disease	Y	N
Hepatitis (yellow jaundice)	Y	N
High blood pressure	Y	N
Kidney disease	Y	N
Kidney stone	Y	N
Migraines	Y	N
Osteoporosis	Y	N
Pneumonia	Y	N
Polio	Y	N
Recurrent bladder infection	Y	N
Rheumatic fever	Y	N
Sleep Apnea	Y	N
Stroke	Y	N
Thyroid disease	Y	N
Tuberculosis	Y	N
Ulcer	Y	N
Other serious illness	Y	N

Please list all operations, including year performed:

Family History (Blood Relatives)		
	Age at Death	If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death.
Father		
Mother		
Maternal Grandparents		
1		
2		
Paternal Grandparents		
1		
2		
Brothers and Sisters		
1		
2		
3		
4		
5		
Children		
1		
2		
3		
4		
(Females) Number of pregnancies: Number of births:		

Health Maintenance (answer applicable questions)
When was last pap smear?
When was last mammogram?
Have you had a bone density test? Y N If yes, when?
Have you had a colonoscopy? Y N If yes, when?
Do you have a Living Will/Advanced Directives? Y N
Immunizations
When was last tetanus vaccine?
Have you had a pneumonia vaccine? Y N If yes, when?

Safety/Social Habits (please circle answers)			
Do you use alcohol?	Y	N	Past
If so, how much per day?			
Do you use tobacco?	Y	N	Past
If yes, how much per day?			
If in past, when did you quit?			
Are you exposed to secondhand smoke in your home?	Y	N	Past
Do you use caffeine, coffee, tea, soda?	Y	N	Past
If so, how much per day?			
Do you use "recreational drugs"?	Y	N	Past
If yes, what do you use?			
Are you sexually active?	Y	N	
If so, with whom?	males	females	both
What do you do for exercise?			
How often do you exercise?			
Have you ever been abused?	physically	mentally	sexually
Are you satisfied with your weight?	Y	N	
Do you always wear a seatbelt?	Y	N	
If you ride a bike or motorcycle, do you always wear a helmet?	Y	N	
Are guns kept in your home?	Y	N	
If yes, is household aware of gun safety?	Y	N	

FORM CONTINUES ON THE OTHER SIDE

Review of Systems

Do you now have, or have you recently had problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in the space provided.

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight loss/gain	Y	N
Other:	Y	N
Ear/Nose/Throat/Mouth		
Ear symptoms	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other:	Y	N
Hematologic/Lymphatic		
Swollen glands	Y	N
Easy bruising	Y	N
Other:	Y	N
Cardiac		
Chest Pains	Y	N
Irregular heartbeats	Y	N
Other:	Y	N
Respiratory		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other:	Y	N
Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Black or bloody stools	Y	N
Diarrhea	Y	N
Other:	Y	N

Genitourinary		
Painful urination	Y	N
Urinary incontinence	Y	N
Blood in urine	Y	N
Other:	Y	N
Dermatologic		
Skin rash	Y	N
Mole change	Y	N
Other:	Y	N
Gynecologic		
Pelvic pain	Y	N
Irregular periods	Y	N
Painful periods	Y	N
Vaginal discharge	Y	N
Other:	Y	N
Musculoskeletal		
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other:	Y	N
Endocrine		
Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other:	Y	N
Psychologic		
Do you have depressed feelings?	Y	N
Have you considered suicide?	Y	N
Sleep disturbance?	Y	N
Other:	Y	N

What do you do for fun?

Physician Use Only: (comments/notes)

# Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____ Date: _____