



Adult Medical History Form

Legal Name: _____ Former Name (if any): _____ DOB: _____ Date: _____

Preferred Name: _____ Pronoun(s): _____ Gender: _____

Marital Status: S M W D Partner

Occupation: _____

If retired, previous occupation: _____

Household (who lives in your household?): _____

List allergies/intolerances to medications: _____

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 surgeries with dates.

Surgery	Date:

Adopted? Y N

Family History (Blood Relatives)

If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death. **Age at Death**

Father _____

Mother _____

Maternal Grandparents

1 _____

2 _____

Paternal Grandparents

1 _____

2 _____

Brothers and Sisters

1 _____

2 _____

3 _____

4 _____

Children

1 _____

2 _____

3 _____

4 _____

Number of Pregnancies (If applicable) _____

Number of Births (If applicable) _____

Health Maintenance (answer applicable questions)

Have you had a pap smear? (If YES list date of last) Date: _____ N

Have you had a mammogram? (If YES list date of last) Date: _____ N

Have you had a bone density test? Date: _____ N

Have you had a colonoscopy? Date: _____ N

Do you have a Living-Will / Advance Directive? Y N

Immunizations (If YES list date of last)

Have you had a tetanus vaccine? Date: _____ N

Have you had a pneumonia vaccine? Date: _____ N

Safety/Social Habits (please circle answers)

Do you drink alcohol? Y N Past

If so, how much per day? _____

Do you use tobacco? Y N Past

If so, how much per day? _____

If used in the past: Start Date: _____ End Date: _____

Are you exposed to secondhand smoke in your home? Y N Past

Do you use caffeine? (circle) coffee tea soda energy-drinks

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 Not Currently Never have

What gender(s) are you attracted to? _____

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

Legal Name: _____ DOB: _____ Date: _____

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

Please explain any YES answers

What do you do for fun?

Practitioner Use Only: (comments/notes)

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