# Medical History Adult

To meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history.

Name: (Last) _____ (First) _____ (Middle) _____

Date of Birth: _____ Age: _____

Height: _____ ft. _____ in. Weight: _____ lbs. (Staff Use: T _____ RR _____ P _____ BP _____ / _____)

Do you have an Optometrist (Eye Doctor): ___ YES ___ NO
Do you have a Dentist: ___ YES ___ NO
Do you have a Therapist/Counselor: ___ YES ___NO

---

**Past Medical History** – Have you ever had the following: ____ Patient denies any past illness

| | Condition | Dates | | Condition | Dates | | Condition | Dates |
|---|---|---|---|---|---|---|---|---|
| | AIDS | | | Epilepsy | | | Pneumonia | |
| | Alcohol | | | Glaucoma | | | Prostate Cancer | |
| | Alzheimer's | | | Heart Disease | | | Sickle Cell Anemia | |
| | Anemia | | | Hyper Cholesterol | | | Stroke | |
| | Arthritis | | | Hypertension | | | Suicidal | |
| | Asthma | | | Hyperthyroidism | | | TIA | |
| | Birth Defects | | | Hypothyroidism | | | Tuberculosis | |
| | Bleeding Disorder | | | Irritable Bowel | | | Ulcer | |
| | Cancer | | | Kidney Disorder | | | Urinary Tract Infection | |
| | COPD | | | Liver Disorder | | | Any other disease | |
| | Depression | | | Lung Cancer | | | Any other disease | |
| | Diabetes | | | Migraine | | | Any other disease | |

---

**Past Surgical History** – Have you ever had the following: ____ Patient denies any past surgeries

**Please list all serious illnesses, operations, and other hospitalizations you have experienced and the dates these occurred**

| | Condition | Dates | | Condition | Dates | | Condition | Dates |
|---|---|---|---|---|---|---|---|---|
| | Appendix | | | Cosmetic | | | Hernia Repair | |
| | Back Surgery | | | C-Section | | | Hysterectomy | |
| | Breast Biopsy | | | D & C | | | Tubal Ligation | |
| | Cataract | | | Gallbladder | | | Tonsil/Adenoids | |
| | Other | | | Other | | | Other | |

---

**Medications** – Please list all medication you are currently taking _____ Patient denies any medications

| Current Medications | Dosage (mg) | How often per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Allergies** – Please list all food, medication, and environmental allergies _____ Patient denies any allergies

| | |
|---|---|
| | |
| | |
| | |

---

**Family History** – Has any blood relative had any of the following: (Leave blank if uncertain)

Patient denies family history of: _____ Breast Cancer _____ Colon Cancer _____GYN Cancer

| Condition | Relationship to you |
|---|---|
| Cancer Type: | |
| Diabetes Type: | |
| Heart Disease | |
| High Blood Pressure | |
| High Cholesterol | |
| Kidney Problem | |

## Menstrual History

Age of 1st period: _____ # of days between period: _____ Total days on period: _____ Date of last period: _____

Flow: _____ Light _____ Medium _____ Heavy Do you tend to clot: YES NO

Method of birth control: _____ Menopause Status: _____ Age when menopause began:_____

Breakthrough Bleeding: YES NO Hormone Replacement Therapy: YES NO

## Pregnancy History

Total number of pregnancies: _____ Full term pregnancies: _____ Premature Births: _____ Multiple births: _____

Terminated Pregnancies: _____ Miscarriages: _____ Ectopic pregnancies: _____ Living: _____

---

## Social History

Tobacco: ____ Never ____Minimal ____YES (_____ packs/day x _____ years) _____ QUIT _____ Years ago (_____ packs/day x _____ years)

Alcohol: ____ Never ____Minimal ____ Less than 10 a week, ____ More than 10 a week, _____ QUIT _____ Years ago

Illicit Drugs: ____ Never ____Minimal ____ YES (_____ packs/day x _____ years) _____ QUIT _____ Years ago (_____ packs/day x _____ years)

Marital Status : ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

Education Level: ____ High School ____College ____ Post Graduate ____ Other

Occupation: _____ Military Service: _____

---

Signature: _____ Date: _____