ADULT HISTORY FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ALLERGIES/REACTION TO MEDICINE

_____

_____

_____

_____

VACCINATIONS _____

TETNUS	☐ YES	☐ NO	LAST DATE: _____
PNEUMONIA	☐ YES	☐ NO	LAST DATE: _____
FLU	☐ YES	☐ NO	LAST DATE: _____

Food Allergies? ☐ YES ☐ NO _____

Latex Allergy? ☐ YES ☐ NO

Please check any of the following tests you have had done in the last year?

DATE OF LAST WELL EXAM/PHYSICAL: _____

☐ CHEST X-RAY ☐ EKG ☐ CHOLESTEROL ☐ GLUCOSE ☐ SIGMOIDOSCOPY

HOSPITAL ADMISSION

NAME OF HEALTH CARE PROVIDER: _____

YEAR	ILLNESS OR OPERATION/PHYSICIAN	YEAR	NAME OF THE OTHER HEALTH CARE PROVIDERS
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT AND FAMILY HISTORY - PLEASE CHECK ALL THAT APPLY.

PLEASE NOTE: "FAMILY" Means any close blood relative.

HEART ATTACK / DISEASE	☐ PATIENT	☐ FAMILY	BONE FRACTURE / JOINT INJURY	☐ PATIENT	
VARICOSE VEINS / PHLEBITIS	☐ PATIENT	☐ FAMILY	GOUT	☐ PATIENT	☐ FAMILY
PEPTIC ULCERS	☐ PATIENT	☐ FAMILY	HIGH BLOOD PRESSURE	☐ PATIENT	☐ FAMILY
DIVERTICULOSIS	☐ PATIENT	☐ FAMILY	PSORIASIS / ECZEMA	☐ PATIENT	☐ FAMILY
GALLBLADDER TROUBLE	☐ PATIENT	☐ FAMILY	DEPRESSION / MENTAL ILLNESS REQUIRING MEDICATION	☐ PATIENT	☐ FAMILY
HIGH CHOLESTEROL	☐ PATIENT	☐ FAMILY	MIGRAINE HEADACHES	☐ PATIENT	☐ FAMILY
KIDNEY PROBLEMS	☐ PATIENT	☐ FAMILY	LUNG DISEASE / ASTHMA	☐ PATIENT	☐ FAMILY
SEXUALLY TRANSMITTED DISEASES	☐ PATIENT		MEASLES / MUMPS / CHICKEN POX	☐ PATIENT	☐ IMMUNIZED
ANEMIA	☐ PATIENT	☐ FAMILY	TB / POLIO / RHEUMATIC FEVER	☐ PATIENT	
DIABETES	☐ PATIENT	☐ FAMILY	HIV (AIDS)	☐ PATIENT	☐ FAMILY
THYROID PROBLEMS	☐ PATIENT	☐ FAMILY	HEPATITIS	☐ PATIENT	☐ FAMILY
STROKE	☐ PATIENT	☐ FAMILY	SICKLE CELL DISEASE	☐ PATIENT	☐ FAMILY
ARTHRITIS	☐ PATIENT	☐ FAMILY			

SEE REVERSE ☞

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SOCIAL HISTORY - PLEASE CIRCLE THE APPROPRIATE ANSWER AND EXPLAIN

Do you drink Alcohol?	YES	NO	If yes, how much? _____	How often? _____
Have you ever smoked cigarettes?	YES	NO	Quit, when? _____	Number of years smoked? _____
Do you currently smoke cigarettes?	YES	NO	If yes, how much? _____	packs per day
Coffee /Tea?	YES	NO	☐ REGULAR ☐ DECAF. _____	Cups per day
Pop?	YES	NO	☐ REGULAR ☐ DIET ☐ DECAF. _____	oz. per day
Are you exposed to blood or body fluids?	YES	NO	Are you expose to fumes or chemicals?	YES NO
Have you ever used illegal drugs?	YES	NO	Do you use seatbelts?	YES NO
Do you exercise regularly?	YES	NO	How often? _____	Type of exercise _____
Are you on any special diet?	YES	NO	Do you wear a helmet when biking/roller blading?	YES NO
Are you currently sexually active?	YES	NO		
Any history of sexually transmitted diseases?	YES	NO	When? _____	What disease? _____

FEMALES ONLY Please check any of the following tests you have had done in the last year?

DATE OF LAST MAMMOGRAM:_____ DATE OF LAST PAP SMEAR:_____

Last Menstrual Period: _____

Flow is: ☐ HEAVY ☐ MODERATE ☐ LIGHT

Flow is: ☐ REGULAR ☐ IRREGULAR

Age of first menses _____ years old

Number days of flow: _____

How often are your periods? every _____ days

Menopause: ☐ YES ☐ NO

TOTAL NUMBER OF PREGANCIES:_____

Number of live births: _____ Number of miscarriages: _____

Number of abortions: _____

Age of first pregnancy: _____ years old

Current method of birth control: _____

Pain / Bleeding after intercourse: ☐ YES ☐ NO

Do you do monthly breast exams? ☐ YES ☐ NO

History of abnormal pap smear: ☐ YES ☐ NO

Patient Signature: _____ Date: _____

OFFICE USE ONLY

HISTORY REVIEWED BY: _____ DATE: _____
SIGNATURE OF PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT