ADULT
PATIENT HISTORY

Date _____

Name _____ Date of birth _____ Sex M ___ F ___

Occupation _____ Marital Status Single _____ Married _____
Divorced _____ Widowed _____

Race _____ Age _____

PAST MEDICAL HISTORY Have you ever had any of the following (Circle)

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	Cataracts
Prostate Trouble	High Cholesterol	Disease	Depression
HIV disease			Trouble Achieving and/or maintaining an erection

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 date or age) PPD _____ Singles _____

Flu _____ Pneumonia _____ Tetanus _____ Hepatitis _____

ADULT
PATIENT HISTORY
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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 (Medication, 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 nonprescription 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?

_____

_____