

Adult Medical History

Name: _____ Today's Date: / ____ / ____
 (Last) (First) (Middle)

Date of Birth: / ____ / ____ Age: _____ Referring Physician: _____

Primary Care Physician: _____
 (Name) (Phone number)

Reason for Visit: _____

PREFERRED PHARMACY:

NAME OF PHARMACY	ADDRESS AND PHONE NUMBER OF PHARMACY
LOCAL -	
MAIL ORDER -	

MEDICAL CONDITIONS: Place X next to all that apply to you

Arthritis		Hepatitis		Skin Disease
Asthma		Heart Disease		Thyroid Disease
Anemia / Blood Disorder		High Blood Pressure		Urinary Incontinence
Diabetes		Kidney Problems		Other:
Gastric Reflux		Migraines		

SURGICAL HISTORY: (ex, C-Section, D&Cs, Pelvic surgery, Appendectomy, Gall bladder removal, etc)

TYPE OF SURGERY:	DATE OF SURGERY: ANY COMPLICATIONS?
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FAMILY MEDICAL HISTORY: Have any of your close relatives had the following?

Condition	Relation	Maternal/ Paternal	Diag Age	Condition	Relation	Maternal/ Paternal	Diag Age
Bleeding Disorder				High Blood Pressure			
Breast Cancer				Diabetes			
Ovarian Cancer				Stroke			
Uterine Cancer				Other:			

NAME: _____ DATE OF BIRTH: ____/____/____

SOCIAL HISTORY:

EMPLOYER / POSITION:	
MARITAL STATUS: (Please Circle): Single / Married / Divorced / Separated / Widowed	
EXERCISE: _____ times per week ACTIVITY:	
SEXUAL HISTORY (Please Circle): Satisfactory / Uncomfortable / Wish to Discuss	
CAFFEINE USE: YES / NO	TYPE HOW OFTEN
ALCOHOL USE: YES / NO	TYPE HOW OFTEN
ILLEGAL DRUGS USE: YES / NO	TYPE HOW OFTEN
TOBACCO USE DO YOU SMOKE? YES / NO	HAVE YOU PREVIOUSLY SMOKED? YES/NO
IF YES, PLEASE ANSWER THE FOLLOWING: How Many Packs Per Day Do You Smoke? How Many Years Have You Been Smoking?	IF YOU ARE A FORMER SMOKER, PLEASE ANSWER THE FOLLOWING: What year did you quit smoking: How many years did you smoke: How many packs per day did you smoke:

ALLERGIES:

NAME OF MEDICATIONS / LATEX:	TYPE OF REACTION TO THE MEDICATIONS:

**CURRENT MEDICATIONS
(PLEASE INCLUDE OVER THE COUNTER MEDICATIONS/VITAMINS/HERBALS):**

MEDICATION NAME:	DOSAGE: (EX. 10MG)	HOW OFTEN: (Ex. Once a day, etc)

HEALTH MAINTENANCE / SCREENING:

	Date of last:		Date of last:		Date of last:		Date of last:
COLONOSCOPY		MAMMOGRAM		GARDASIL		TETANUS	
PAP SMEAR		BONE DENSITY		FLU VACCINE			

PLEASE NOTE THAT ALL HEALTH INFORMATION IS CONFIDENTIAL. WE WILL NOT RELEASE ANY INFORMATION WITHOUT YOUR SIGNED CONSENT. INFORMATION MAY BE RELEASED TO MEDICAL CONSULTANTS IF YOU ARE REFERRED.

NAME: _____ DATE OF BIRTH: ____ / ____ / ____

OBSTETRIC HISTORY:

TOTAL PREGNANCIES: _____ FULL TERM: _____ PRETERM: _____ MULTIPLE BIRTHS: _____ No. of INDUCED ABORTIONS: _____ MISCARRIAGES: _____ ECTOPICS: _____

	Year Delivered	Weeks Pregnant	Hours in Labor	Weight	Sex	Delivery Type	Hospital	Complications
1								
2								
3								
4								
5								
6								

GYNECOLOGIC HISTORY:

<p>AGE OF FIRST PERIOD: _____ REGULAR CYCLES: YES / NO CYCLE LENGTH (from start to start): ____ DURATION OF FLOW (# of days): _____ FLOW (light / med / heavy): _____ CRAMPS: None / Light / Moderate / Intense MEDICATION FOR CRAMPS: _____ 1st DAY OF LAST PERIOD: _____</p>	<p>DATE OF LAST PAP SMEAR: _____ HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR: YES / NO If yes, when: _____ Treatments: _____ ARE YOU SEXUALLY ACTIVE: YES / NO SEXUAL ORIENTATION: Heterosexual / Homosexual / Bisexual / Transexual</p>
<p>PELVIC INFECTIONS: <u>Have You Been Diagnosed and/or Treated For:</u> Yeast _____ Trichomonas _____ Herpes _____ Syphilis _____ Chlamydia _____ Pelvic Inflammatory Disease _____ Gonorrhea _____ HIV _____</p>	<p>CURRENT METHOD OF CONTRACEPTION: _____ HOW LONG HAVE YOU BEEN ON THIS METHOD: _____ WHAT CONTRACEPTION METHODS HAVE YOU TRIED BEFORE: _____</p>

REVIEW OF SYSTEMS: *Please circle any symptoms that you are CURRENTLY having:*

<p>CONSTITUTIONAL Weight loss Weight gain Fever Fatigue</p>	<p>CARDIOVASCULAR Chest pain Swelling Palpitations</p>	<p>SKIN Breast discharge Breast lump Hair loss Rash Skin lesion</p>	<p>NEUROLOGIC Dizziness Numbness Trouble walking Headache Seizures</p>
<p>HEAD, EYES, EARS, NOSE, THROAT Ear pain or drainage Eye pain or drainage Hearing Loss Nasal drainage Sinus pressure Sore Throat Vision changes Ringing in ears</p>	<p>GASTROINTESTINAL L Abdominal pain Blood in stools Constipation Diarrhea Heartburn Nausea Vomiting</p>	<p>MUSCULOSKELETAL L Back pain Joint pain Joint swelling Muscle weakness Neck pain</p>	<p>Hematologic/Immunologic Easy bleeding Easy bruising Swollen lymph nodes Environmental/seasonal allergies Food allergies</p>
<p>RESPIRATORY Chronic cough Cough Shortness of breath Wheezing</p>	<p>GENITOURINARY Pain with urination Blood in urine Urinary frequency Incontinence Incomplete emptying</p>	<p>ENDOCRINE Cold intolerance Heat intolerance Abnormal thirst Abnormal hunger</p>	<p>PSYCHIATRIC Anxiety Depression Insomnia</p>
<p>REPRODUCTIVE Painful periods Painful intercourse Irregular periods Vaginal discharge</p>		<p>OTHER SYMPTOMS:</p>	