# ADULT MEDICAL HISTORY FORM

Name: _____ **Birth date:** _____

## History of the Present Illness

What is the reason for your visit today? _____

## Past Medical History:

- ☐ Alcoholism
- ☐ Allergy / Asthma
- ☐ Obesity
- ☐ Thyroid Disorders
- ☐ Other _____
- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Other _____
- ☐ Kidney Stones
- ☐ High Cholesterol
- ☐ Glaucoma

## Past Surgical History:

- Surgery (Name) _____ Hospital: _____ Year: ____
- Surgery (Name) _____ Hospital: _____ Year: ____
- Surgery (Name) _____ Hospital: _____ Year: ____

## Current Medications (please list):

| Medication Name | Strength | Frequency | Medication Name | Strength | Frequency |
|---|---|---|---|---|---|
| 1. | | | 5. | | |
| 2. | | | 6. | | |
| 3. | | | 7. | | |
| 4. | | | 8. | | |

## Allergies(Medications):

## Immunizations:

- Last Tetanus Booster (Date): _____
- Last Pneumovax (Date): _____
- Last Skin Test for TB (Date): _____
- Last Flu Vaccine (Date): _____
- Last Hepatitis B Vaccine (Date): _____

## Family History:

Please indicate with a check any of the following medical problems within your family history:

| | Self | Mother | Father | Sibling | Grand Parent | Uncle /Aunt | | Self | Mother | Father | Sibling | Grand Parent | Uncle /Aunt |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | | | | | | | Stroke | | | | | | |
| Allergy or Asthma | | | | | | | Obesity | | | | | | |
| Heart Attack | | | | | | | Alcoholism | | | | | | |
| Diabetes | | | | | | | Glaucoma | | | | | | |
| High Cholesterol | | | | | | | Seizures | | | | | | |
| Cancer | | | | | | | Thyroid Disorders | | | | | | |
| Arthritis | | | | | | | HIV or AIDS | | | | | | |
| Kidney Stones | | | | | | | Bleeding Disorders | | | | | | |

## Social History:

Do you currently smoke? ☐ Yes ☐ No. If yes, how many packs per day ____ for how many years ____

Do you drink alcoholic beverages? ☐ Yes ☐ No. If yes, Amount per week _____

Have you ever used any recreational drugs (like marijuana/cocaine/heroin/intravenous drugs)? ☐ Yes ☐ No

If yes, Amount per week _____

**Signature of Patient / Person Filling Out Form** _____ **Date:** _____

**Provider Signature** _____ **Date:** _____