Adult History Form

Name:______________________________ Age:________ Date:______________

Please print

1. List any medications you take, including over the counter medicines, vitamins, or 'home remedies':

Regularly			***Occasionally***		
Medication Name	*Dose*	*Frequency*	*Medication Name*	*Dose*	*Frequency*
1.					
2.					
3.					
4.					
5.					

2. List any medications to which you have had an allergic reaction or cannot take:

1. ______________________ Reaction:______________________

2. ______________________ Reaction:______________________

3. ______________________ Reaction:______________________

3. List any childhood illnesses/immunizations and the approximate date of the illness or immunization:

1. ______________ Date:________ 4. ______________ Date:________

2. ______________ Date:________ 5. ______________ Date:________

3. ______________ Date:________ 6. ______________ Date:________

4. Have you ever had any of the following? Please give approximate year:

[ ] Glaucoma	[ ] Gallbladder X-Ray	[ ] Anemia	[ ] Asthma
[ ] Ulcers	[ ] Excessive Bleeding	[ ] Tuberculosis	[ ] Stomach X-Ray
[ ] X-ray or radiation treatments	[ ] Heart Condition	[ ] Vomit Blood	[ ] Heart Murmur
	[ ] Stroke	[ ] Paralysis	[ ] Rheumatic Fever
[ ] Black Bowels	[ ] Heart Attack	[ ] Angina Pectoris	[ ] Colitis
[ ] High Blood Pressure	[ ] Kidney Condition	[ ] Arthritis	[ ] Convulsions
[ ] Bladder Infection	[ ] Drug Dependency	[ ] Mental Illness	[ ] Gout
[ ] Alcohol Dependency	[ ] Hepatitis	[ ] Yellow Jaundice	[ ] Prostate Trouble
[ ] Liver Disorder	[ ] Blood Clot	[ ] Venereal Disease	[ ] Thyroid Disorders
[ ] Phlebitis	[ ] Diabetes	[ ] Goiter	[ ] Gallbladder Disorder
[ ] Meningitis	[ ] Blood in Bowels	[ ] Blood Sugar too high	

Other Medical Illness Not Listed:______________________________

5. List any hospitalization for illnesses or tests not requiring surgery (include psychiatric):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

6. List any surgeries you have had and the approximate date:

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

7. Family History

	Sex		If Living Age	Health	If Deceased Age at Death	Cause of Death/ Other Illness
Father						
Mother						
Brother/Sister * (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				
Husband/ Wife						
Sons/Daughters (Circle Sex)						
	M	F				
	M	F				
	M	F				
	M	F				

*Since some names may be used for either men or women, please circle sex for each Brother Sister, Son, or Daughter. Have any Blood Relatives had the following: Diabetes, High Blood Pressure, Heart Disease, Kidney Disease, Cancer (if so, what?), Nerve Problems, Bleeding Disorders. (Circle and Explain)

8. How many of the following do you consume daily?

_______Cigarettes _______Beer _______Coffee _______Cigars _______Wine

_______Tea _______Pipe _______Hard Liquor _______Soft Drinks

9. Have you experienced the following in the past ONE MONTH? (Circle)

Hearing Loss	Wheezing	Fainting, passing out
Ringing in ears	Vomiting	Tired -Morning? Noon? Evening
Dizziness	Urge to Vomit	All Day?
Failing Vision	Abdominal pain (Stomach)	Weak -All over? One Limb? Mild
Eye Pain	-Worse when stomach full?	Severe?
Hoarseness	-Worse when empty	Skin Rash
Chest Pain -Heavy Sharp?	-Associated with vomiting?	Awaken every night to void urine?
Crushing? Stabbing	-Any urge to vomit?	Once? Twice? Three? Four?
Is it worse when: Breathing?	-Any loose bowels from pain?	Painful voiding (urinating)
-Bending? Exerting? Excited?	Persistent loss of appetite	Bloody Urine
-Worried? Tired? Active	Constipation	Weak Stream
Shortness of breath; at rest?	Diarrhea	Urinary Discharge
-During mild exertion	Joint discomforts or stiffness	Cannot hold urine
-During Heavy exertion?	Legs hurt when walk too fast or	Sexual problems
-When worried?	too far, Feel better is slow down?	Voiding (urinating) too often
-While lying down?	Stop? Feet swell in the AM? PM?	IN THE PAST YEAR has there
-Breath better sitting up?	Nervousness or depression	been a change in bowels? Explain:
Cough all day?	Hard to swallow or painful	
-Just in the morning?	Trouble sleeping	
-Raise up phlegm?	Headaches - Front? Back?	IN THE PAST YEAR has there
-Raise up blood?	One side? Throb? Pressure?	been a change in weight? Up?
		Down? How Much?

10. When was your last Period?__________ When was your last Pap Smear?_______

Number of Pregnancies?_____________ Number of Miscarriages?____________