 Adult History Form

Welcome to our clinic! In order for us to serve you better, please fill out this medical history form as accurately as possible. Thank you!

Name ____ Date of birth _________________

Gender _______ Language ____________________________________

Race/Ethnicity: ___Black ___White ___Asian ___Hispanic ___Other ___________

Medical History (current and past medical conditions)

Month/Year Diagnosed	Condition

Allergies

Agent/Substance/Medication	Reaction

Medication List

Please include inhalers, medication patches, nasal sprays, over-the-counter meds and supplements.

Name	Strength (e.g. mg dose)	Formulation (e.g. liquid, tablet or capsule)	Dose (i.e. how many, e.g. 1 tab)	Frequency (e.g. once daily)

Family History

Indicate if any blood relatives have had any of these conditions: Alcoholism, Arthritis, Asthma, Hay Fever, Cancer, Cirrhosis, Diabetes, Emphysema, Epilepsy, Gout, Heart, High Blood Pressure, Kidney Disease, Kidney Stones, Migraines, Sickle Cell, Stroke, Suicide, Mental Illness, Thyroid, Tuberculosis, Bleeding Tendency

Family Member	**Alive/Deceased**	**Year of birth**	**Medical conditions, if any**
Father			
Mother			
Brother 1			
Brother 2			
Brother 3			
Sister 1			
Sister 2			
Sister 3			
Paternal grandfather			
Paternal grandmother			
Maternal grandfather			
Maternal grandmother			

		Number		Number	Healthy?
Siblings	Brothers		Sisters		
Children	Sons		Daughters		

Additional family history:

Surgical History

Month/Year	Surgery

Hospitalizations

Month/Year	Reason

Preventive Services- Please print the date (month/year) that you last received each service below.

Month/Year	Service Received
	Pap smear (females only)
	Mammogram (females only)
	Bone densitometry (females only)
	Prostate screening (males only)
	Colonoscopy
	Cholesterol screening
	Eye examination
	Pneumonia vaccination
	Tetanus vaccination

Adult Social History

- **Tobacco** -- Are you a:
  - current smoker -- ☐ every day ☐ some days or ☐ unknown
  - former smoker
  - nonsmoker
  - unknown if ever smoked
  - other tobacco user
- **Sexual history**
  - Have you had sex in the past 12 months (vaginal, oral or anal)? ☐ Yes ☐ No
  - Have you ever had a sexually transmitted disease? ☐ Yes ☐ No
  - Last menstrual period _______________
  - Sexual preference: ☐ heterosexual ☐ homosexual ☐ bisexual
- **Alcohol** -- Did you have a drink containing alcohol in the last year? ☐ Yes ☐ No
  If 'Yes':
  - How often did you have a drink containing alcohol in the last year?
    ☐ Monthly or less
    ☐ 2-4 times a month
    ☐ 2-3 times a week
    ☐ 4 or more times a week
  - How many drinks did you have on a typical day when you were drinking in the past year?
    ☐ 1 or 2 drinks
    ☐ 3 or 4 drinks
    ☐ 5 or 6 drinks
    ☐ 7 to 9 drinks
    ☐ 10 or more drinks
  - How often did you have 6 or more drinks on one occasion in the past year?
    ☐ Never
    ☐ Less than monthly
    ☐ Monthly
    ☐ Weekly
    ☐ Daily or almost daily

- **Drug use?** ____

- **Personal History**
  - Occupation: _____________________
  - Marital status: ____________________
  - Caffeine: _______________________
  - Exercise: _______________________