Date _____

Adult Patient History

Chart # _____

MRN # _____

Name: _____ Age: _____ Date of Birth _____ Sex: M F

Marital Status: Single Married Widowed Divorced Occupation: _____

Spouse/Significant Other Name: _____ Education: Highest Level Completed _____

What is the reason for your visit today? _____ Who referred you? _____

Vaccines	Approximate Date
Tetanus	
Flu	
Hep B	
Pneumovax	
MMR	
Chicken pox	
TB skin Test Positive Negative	

Exams	Approximate Date
Last Dental exam	
Last Eye exam	
Last Chest X-ray	
Last Colonoscopy/Sigmoidoscopy	
Last Mammogram	
Last Pap Smear	
Last Physical Exam	
Last Prostate Exam/PSA	
Other _____	

FAMILY HEALTH HISTORY:

Check (✔) if you or any blood relative has or has had any of the following and enter their relationship to you: *(Use the following abbreviations)* ***Y - yourself M - mother F - father B - brother S - Sister GF - grandfather GM - grandmother C - child***

Condition	Relationship	Condition	Relationship
Heart disease		Rheumatic fever	
Lung disease *(asthma, bronchitis, emphysema, TB, etc.)*		Stomach/Intestinal disorders	
Cancer *(breast, prostate, melanoma, leukemia, etc.)*		Gallbladder disorders	
Stroke		Thyroid disorders *(goiter)*	
High Blood Pressure		Gout	
Diabetes		Skin disorders	
Liver disease *(hepatitis, cirrhosis, jaundice, etc.)*		Depression or other Mental Illness	
Kidney disorders *(including kidney stones)*		Sexually transmitted disease *(HIV, Herp., PID, etc.)*	
Arthritis		Alcohol/Drug abuse	
Blood disorders *(anemia, bleeding disorders, etc.)*		Risk factors for HIV	
High Cholesterol		Migraines/Headaches	
Allergies *(food, seasonal)*		Other _____	

Current Medications – Prescription and Over-The-Counter Meds.
(including vitamins, herbs, aspirin, antacids, injectables, hormones)

Birth Control *(Oral, Injectable)*

Are you allergic to any medicine? ☐ **Yes** ☐ **No**
Please list all medications and reactions

Past hospitalizations/surgeries/serious injuries
(including blood transfusions)

Do You	Yes	No	Type	Amt./Day	Date Quit
Use tobacco products	☐	☐			
Consume alcohol	☐	☐			
Drink caffeine	☐	☐			
Use or used illegal drugs	☐	☐			
Exercise regularly	☐	☐			
Have diet restrictions	☐	☐			
Travel outside US	☐	☐			

See Reverse Side