



## ADULT HISTORY FORM

*Instructions: Please fill out as complete as possible. All information will be kept confidential.*

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

### CURRENT MEDICAL PROBLEMS

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and indicate the name of the physician treating you.

PROBLEM/DISEASE	PHYSICIAN

### SURGICAL HISTORY

### PHYSICIAN (SURGEON)

- |   |                                    |  |   |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Gall Bladder               | <input type="checkbox"/> Tonsils   | <input type="checkbox"/> Appendix        | <input type="checkbox"/> Uterus/Ovaries |
| <input type="checkbox"/> Hernia                     | <input type="checkbox"/> C-Section | <input type="checkbox"/> Coronary Bypass |   |
| <input type="checkbox"/> Other (please list): _____ |                                    |  |   |


Please mark with an (X) any of the following illnesses and medical problems you have or have had and indicate the year when each started. If you are not certain when an illness started, write down an approximate year. For any additional comments/explanations, use the back page.

ILLNESS	X	YEAR	ILLNESS	X	YEAR	ILLNESS	X	YEAR
Glaucoma	<input type="checkbox"/>	_____	Other heart condition	<input type="checkbox"/>	_____	Blood clot	<input type="checkbox"/>	_____
Other eye problems	<input type="checkbox"/>	_____	Stomach/Duodenal ulcer	<input type="checkbox"/>	_____	Thyroid disease	<input type="checkbox"/>	_____
Hearing loss	<input type="checkbox"/>	_____	Diverticulosis	<input type="checkbox"/>	_____	Head injury	<input type="checkbox"/>	_____
Bronchitis	<input type="checkbox"/>	_____	Colitis	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	_____	Gall Bladder	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	_____	Cancer or tumor	<input type="checkbox"/>	_____
Allergy (seasonal, perennial, pets)	<input type="checkbox"/>	_____	Yellow jaundice	<input type="checkbox"/>	_____	Sickle Cell Disease	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	_____	Liver trouble	<input type="checkbox"/>	_____	Bleeding tendency	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	_____	Anemia	<input type="checkbox"/>	_____
Other lung problems	<input type="checkbox"/>	_____	Hernia	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	_____	Hemorrhoids	<input type="checkbox"/>	_____	Skin conditions	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	_____	Kidney or bladder disease	<input type="checkbox"/>	_____	Mental Illness/depression	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	_____	Kidney stones	<input type="checkbox"/>	_____	Measles, Mumps	<input type="checkbox"/>	_____
Arteriosclerosis	<input type="checkbox"/>	_____	Prostate problem	<input type="checkbox"/>	_____	Chicken pox	<input type="checkbox"/>	_____
HIV	<input type="checkbox"/>	_____	Migraine headaches	<input type="checkbox"/>	_____	Blood transfusion	<input type="checkbox"/>	_____
Polio/Rheumatic Fever	<input type="checkbox"/>	_____	Epilepsy/seizures/ convulsions	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	_____					<input type="checkbox"/>	_____

### OTHER ILLNESSES

### MEDICAL ALLERGIES

ILLNESS	X	YEAR
	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____
	<input type="checkbox"/>	_____

*i.e. Penicillin, Sulfa, Aspirin I.V. Dye, etc.*

<b>ALLERGIC TO:</b> _____	<b>REACTION:</b> _____
Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No	





### SYSTEM REVIEW

Place a mark in the box for each item that you have now or have had in the past and where applicable, please fill in additional information.

<b>GENERAL</b>	<input type="checkbox"/> weakness	<input type="checkbox"/> chills	<input type="checkbox"/> change in weight, appetite or sleeping habits	
	<input type="checkbox"/> fatigue	<input type="checkbox"/> night sweats		
<b>SKIN</b>	<input type="checkbox"/> itching	<input type="checkbox"/> rash	<input type="checkbox"/> change in color	<input type="checkbox"/> easy bruising
<b>NERVOUS SYSTEM</b>	<input type="checkbox"/> headache	<input type="checkbox"/> double vision	<input type="checkbox"/> dizziness	<input type="checkbox"/> tremor/handshaking
	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> loss of coordination	
<b>CARDIOVASC. SYSTEM</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> trouble breathing at night	<input type="checkbox"/> easy fatigue	<input type="checkbox"/> blood clots/phlebitis
	<input type="checkbox"/> palpitations (heart pounding)	<input type="checkbox"/> trouble climbing stairs	<input type="checkbox"/> ankle swelling	
<b>GASTRO-INTESTINAL</b>	<input type="checkbox"/> stomach pain/abdominal pain	<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> changes in bowel habits	
	<input type="checkbox"/> indigestion/heart burn	<input type="checkbox"/> vomiting/nausea	<input type="checkbox"/> blood in stools	
	<input type="checkbox"/> black, tarry stools	<input type="checkbox"/> diarrhea/constipation	<input type="checkbox"/> loss of control of bowels	
<b>URINARY</b>	<input type="checkbox"/> pain with urination	<input type="checkbox"/> frequent urination	<input type="checkbox"/> difficulty starting to urinate	<input type="checkbox"/> blood in urine
	<input type="checkbox"/> previous infections	<input type="checkbox"/> loss of control of bladder		
<b>EYES</b>	<input type="checkbox"/> glasses/contacts	<input type="checkbox"/> excessive tearing	<input type="checkbox"/> last eye exam date: _____	
	<input type="checkbox"/> eye pain	<input type="checkbox"/> blurring or spots		
<b>EARS</b>	<input type="checkbox"/> loss of/or decreased hearing		<input type="checkbox"/> ringing in ears	<input type="checkbox"/> drainage
<b>NOSE/THROAT/SINUSES</b>	<input type="checkbox"/> nosebleeds	<input type="checkbox"/> hoarseness	<input type="checkbox"/> swelling	<input type="checkbox"/> sore throat <input type="checkbox"/> post nasal drip
<b>MOUTH</b>	<input type="checkbox"/> dentures	<input type="checkbox"/> bleeding gums	<input type="checkbox"/> toothache	<input type="checkbox"/> last dental exam: _____
<b>JOINTS &amp; BACK</b>	<input type="checkbox"/> pain	<input type="checkbox"/> swelling	<input type="checkbox"/> stiffness	<input type="checkbox"/> deformity
<b>MUSCLES</b>	<input type="checkbox"/> pain	<input type="checkbox"/> weakness	<input type="checkbox"/> twitching	
<b>ENDOCRINE</b>	<input type="checkbox"/> excessively hot	<input type="checkbox"/> always thirsty	<input type="checkbox"/> high cholesterol	
	<input type="checkbox"/> excessively cold	<input type="checkbox"/> always hungry (last cholesterol check was _____)		
<b>PSYCHOLOGICAL</b>	<input type="checkbox"/> nervousness	<input type="checkbox"/> unable to sleep	<input type="checkbox"/> memory loss	<input type="checkbox"/> anorexia/bulimia
	<input type="checkbox"/> depression	<input type="checkbox"/> nightmares	<input type="checkbox"/> mood swings/anxiety	
<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Tetanus date: _____	<input type="checkbox"/> Influenza date: _____	<input type="checkbox"/> Chicken Pox date: _____	
	<input type="checkbox"/> German Measles date: _____	<input type="checkbox"/> Pneumococcal date: _____	<input type="checkbox"/> Hepatitis B Series date: _____	
<b>MALES</b>	<input type="checkbox"/> hernia	<input type="checkbox"/> pain in testicles	<input type="checkbox"/> sexual difficulties	<input type="checkbox"/> discharge from penis
<b>FEMALES</b>	<input type="checkbox"/> vaginal itching or burning	<input type="checkbox"/> last Pap smear date: _____	<input type="checkbox"/> problems during pregnancy	
	<input type="checkbox"/> vaginal discharge	<input type="checkbox"/> methods of contraception: _____	<input type="checkbox"/> lumps in breast	
	<input type="checkbox"/> age at first menses: _____	<input type="checkbox"/> age at first intercourse: _____	<input type="checkbox"/> Do monthly breast exam	
	<input type="checkbox"/> periods occur every _____ days	<input type="checkbox"/> pregnancy, number: _____	<input type="checkbox"/> discharge from nipple	
	<input type="checkbox"/> number of days flowing _____	<input type="checkbox"/> age at first pregnancy: _____	<input type="checkbox"/> last mammography date: _____	
	<input type="checkbox"/> is flow regular	<input type="checkbox"/> miscarriages or	<input type="checkbox"/> Pain/bleeding with intercourse	
	<input type="checkbox"/> problems with menstrual periods	abortions, number: _____	<input type="checkbox"/> menopause	
	<input type="checkbox"/> last menstrual period date: _____	<input type="checkbox"/> live births, number: _____		

### SIGNS, SYMPTOMS AND DISEASES NOT COVERED ABOVE (additional space on back)

\_\_\_\_\_

### SIGNATURES

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

M.D./N.P./P.A. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature indicates history reviewed)

