ADULT HISTORY FORM

Your answers on this form will help your provider understand your medical concerns and conditions better. Best estimates are fine if you cannot remember specific details. Thank you!

NAME: __________________________ DOB:_________ AGE:_____ Today's Date________

Referred By_________________________ PCP_________________________________

MEDICAL HISTORY:
How would you rate your general health? Excellent___ Good___ Fair___ Poor___
Present health concerns:
____
____

***CURRENT MEDICATIONS*:**
Please list all your prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, include the prescribing physician
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

PHYSICIANS SEEN:____
____

ALLERGIES or REACTIONS TO MEDICINES:
____
____

PERSONAL MEDICAL HISTORY:

CAFFEINE Intake: None____ Coffee/tea: ____ cups/day Sodas: ____ /day Chocolate: ____ oz/day
WEIGHT: Are you satisfied with your weight? N____ Y____
DIET: How do you rate your diet? Good____ Fair____ Poor____
Do you take ***SUPPLEMENTS***? N____ Y____
Do you drink 4 lg. glasses of milk daily or take ***CALCIUM*** supplements? Y____ N____

Do you *EXERCISE* regularly? N____ Y____
What kind of exercise? ________________________________

How long (minutes) _____ How often? _____________________
If you do not exercise, why? _____________________________

Please indicate whether you have had any of the following medical problems (with dates):

____________Heart Disease: specify type _____________________ ____________Heart attack
____________Diabetes ____________High Blood Pressure
____________High cholesterol ____________Thyroid Problem
____________Bleeding/clotting problem ____________Blood Transfusion
____________Cancer (Malignancy) specify type________________ ____________Stroke
Other problems (specify):

MEDICAL HISTORY (Cont'd)

SURGICAL HISTORY
Please list all prior operations (with dates):

PAST AND FAMILY MEDICAL HISTORY:
Please indicate which of the following medical conditions apply to you or a family member.

CONDITION	Family History *Specify member*	CONDITION	Family History *Specify member*	CONDITION	Family History *Specify member*
Allergies		Anemia		Arthritis	
Asthma		Bleeding Disorder		Cancer-Type	
Diabetes		Headaches		Heart Disease	
High Blood Pressure		High Cholesterol		Hearing Problems	
Hay Fever		Immune Disease		Kidney Disease	
Liver Disease		Mental Retardation		Mental Disorder	
Osteoporosis		Seizures/ Epilepsy		Strokes	
Substance Abuse		Smoking		Thyroid Disease	
High Blood Pressure		Seizures/ Epilepsy			

Other		Other		Other	

SUBSTANCE USE HISTORY

Please use the chart below to describe your use of the following: tobacco, alcohol, recreational drug use

Substance	***Age of first use***	***Current Use***	***Frequency/ Amount***	***Past Use (dates)***	***Received Treatment***	***Type of Treatment***

MENTAL HEALTH HISTORY

Have you ever participated in the following treatments? (If yes please complete section below)

Service	***Dates of service***	***Where/Whom***	***Medication?***	***Satisfied with treatment?***
Outpatient				
Intensive Outpatient				
Partial Hospitalization				
In patient				

Is violence at home a concern for you? N____ Y____ If yes, please elaborate ___________________
Have you ever been abused? N____ Y____ If yes, please elaborate ___________________________
Do you have a gun in your home? N____ Y____

SOCIAL HISTORY

Highest year of education completed__________________ Degree Obtained____________
Date obtained____________
Current occupation? ________________ Years at current position___________________________
Prior work experience____
How many days of work have you missed because of illness in the last month? ____
Last 6 months____ Last 1 year ____
Current marital status____ Single____ Married____ Committed relationship____ Divorced____
Widowed____
Prior Marriages N____ Y____ If yes, please elaborate____________________________________
Religious Preference (if any) ____

Please list your interests, activities, community or church involvements ____________________
____

Adult family structure (list all household members (including any children not living with you)

NAME	***RELATIONSHIP***	***AGE***	***LIVING? Y/N***	***COMMENT ON RELATIONSHIP***