

ADULT MEDICAL HISTORY FORM

Please complete all pages. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

PRESENT HEALTH CONCERN: _____

MEDICATIONS: Prescription and vitamins, home remedies, birth control pills, herbs and other:

<i>Medication</i>	<i>Dose</i>	<i>Times per day</i>

ALLERGIES or REACTIONS TO MEDICINES/FOOD/OTHER/OTHER AGENTS:

<i>Medication/Agent</i>	<i>Reaction or Side Effect</i>

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following problems:

<i>Medical conditions</i>	()	<i>Date</i>	<i>Medical Conditions</i>	()	<i>Date</i>
Congenital Heart disease			Bleeding/clotting disorder		
Heart Attack(MI)			Cancer: _____		
High Blood Pressure			Depression/suicide attempt		
Diabetes			Alcoholism		
High cholesterol			Blood Transfusion		
Stroke			Abnormal Pam smear		
Thyroid problem			Other:		

SURGICAL HISTORY (Please list all prior operations and approximate date):

<i>Operation</i>	<i>Date</i>	<i>Operation</i>	<i>Date</i>
1.		4.	
2.		5.	
3.		6.	

WOMEN'S GYNECOLOGIC HISORY:

For Women: # pregnancies: _____ # deliveries: _____ # abortions: _____ # miscarriage: _____
 1st day, most recent period: _____ Age at 1st period: _____ Frequency of periods: _____ Length: _____
 Do you have any concern about your periods? No Yes: _____ NA

FAMILY HISTORY: Please indicate with a check () family member who have had any of the following:

<i>Medical Conditions</i>	<i>Mom</i>	<i>Dad</i>	<i>Brother</i>	<i>Sister</i>	<i>Grand Mother</i>	<i>Grand Father</i>	<i>Dau.</i>	<i>Son</i>	<i>Other</i>
Alcoholism									
Anemia									
Hay Fever									
Asthma									
Arthritis									
High Blood Pressure									
Coronary Artery Disease									
High cholesterol									
Cancer, Breast									
Cancer, Colon									
Cancer, Ovary									
Cancer, Prostate									
Mitral Valve Prolapse									
Migraine headaches									
Osteoporosis									
Diabetes									
Depression									
Thyroid disorder									
Stroke									
Seizures									
Other									

SOCIAL HISTORY:

Cigarettes: Never_____. Quit: Date _____. Current Smoker: _____ packs/day. # of yrs_____.
 Other Tobacco: Pipe Cigar Snuff Chew
 Are you interested in quitting? No Yes

Alcohol: Do you drink alcohol? NO Yes: # drink/week _____
 Is alcohol use a concern for you or others? No Yes

Drug Use: Do you use any recreational drugs? No Yes
 Have you ever used needles? No Yes

Exercise: Do you exercises regularly? No Yes: _____ times/week.

SOCIOECONOMICS: Occupation: _____
 Education completed: Grade school_____. High school _____. College Graduate_____.
 Marital status: Single_____. Married_____. Sep_____.
 Divorced_____. Widow_____. Other: _____.
 Number of children: _____
 Who lives at home with you? _____

SEXUALITY: Sexually Active: Yes No Not currently
 Current sex partner(s) is/are: Male Female NA
 If sexually active, do you practice safe sex? No Yes NA

Have you ever had any sexually transmitted diseases (STDs)? No Yes NA

If yes, please include: _____

Are you interested in being screened or sad **much of the time** in the past year? No Yes

Other concerns? _____

IMMUNIZATION: Please list your most recent immunizations. Please include your best estimate of the month and year of each immunization:

<i>Vaccine</i>	<i>Date</i>	<i>Vaccine</i>	<i>Date</i>
Tetanus (Td)		MMR	
Hepatitis A		Pneumonia	
Hepatitis B		Chicken Pox	
Meningococcal		Other:	

REVIEW OF SYSTEMS: Please check () any **current problems** you have on the list below.

<i>Constitutional</i>	()	<i>Cardiovascular</i>	()	<i>Genitourinary</i>	()
Fevers/chills/sweats		Chest pain/discomfort		Nighttime urination	
Unexplained weight loss/gain		Leg pain with exercise		Leaking urine	
Fatigue/weakness		Palpitations		Unusual vaginal bleeding	
Excessive thirst or urination		Irregular heart beat		Sexual function problems	
<i>Eyes</i>		<i>Respiratory</i>		<i>Musculo-skeletal</i>	
Change in vision		Cough/wheeze		Muscle/joint pain	
Double vision		Difficulty breathing		Back pain	
<i>Ears/Nose/Throat/Mouth</i>		<i>Gastrointestinal</i>		<i>Skin</i>	
Difficult hearing		Abdominal pain		Rash or Mole change	
Ringin I the ears		Blood in bowel movement		<i>Neurological</i>	
Problems with teeth/gums		Nausea/vomiting/diarrhea		Headaches	
Hay fever/allergies		Heart Burns		Dizziness/light-headedness	
<i>Blood/Lymphatic</i>		<i>Psychiatric</i>		<i>Numbness/Tingling</i>	
Unexplained lumps		Anxiety/stress		Memory loss	
Easy bruising/bleeding		Problems wit sleep		<i>Other(Please specify)</i>	
		Depression			

Above information is correct to the best of my knowledge and I release Sanjay A. Thakkar, MD of any liabilities as a result of false, incomplete or omitted information.

Signature: _____
(Patient or Guardian)

Date ___/___/_____