



FORM 1 - PHA-ADULT MEDICINE, PC - - - -ADULT MEDICAL HISTORY

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Main Reason for today's visit: \_\_\_\_\_

Are you in good general health?  No  Yes

List all prescribed and over-the-counter drugs you are taking with doses

What are you allergic to?  Penicillin,  sulfa drugs,  x-ray dyes,  ace inhibitors  shell fish  Other substances? \_\_\_\_\_

IMMUNIZATIONS (year you received)

Hepatitis A \_\_\_ Hepatitis B \_\_\_ Pneumonia \_\_\_
Influenza(flu) \_\_\_ Tetanus \_\_\_ Swine Flu vaccine \_\_\_
Tetanus & Pertussus (Tdap) \_\_\_
Measles, Mumps, Rubella (MMR) \_\_\_
Varicella Vaccine (chickenpox) \_\_\_ Meningitis \_\_\_

ENTER THE DATE YOU LAST RECEIVED THESE TEST

Colonoscopy (colon cancer) \_\_\_ Glaucoma \_\_\_
Mammogram (breast cancer) \_\_\_ PSA (Prostate Cancer) \_\_\_
Dexacan (osteoporosis) \_\_\_ Last Pap Smear \_\_\_

LIFESTYLES SURVEY

Do you wear seatbelt?  NO  YES
Do you wear a bike helmet?  NO  YES
Do you smoke?  NO  YES If yes, how many cigs per day? \_\_\_
Do you drink alcohol?  NO  YES. How many per week? \_\_\_
Do you drink coffee or tea? If yes, how much:  NO  YES
Is there a gun at home?  NO  YES
If yes, is it out of children's reach and unloaded?  NO  YES
Do you use recreational drugs?  NO  YES
Have you used needles to inject drugs?  NO  YES
Are you sexually active?  NO  YES
Current sex partners is/are  Male  Female
Birth Control Method is \_\_\_
Do you wish to be tested for HIV?  NO  YES
Have you worked with asbestos or other hazardous materials?  NO  YES
Do you exercise regularly?  NO  YES
Do you have a Living Will or Power of Attorney  NO  YES
Is violence a concern in your home?  NO  YES
My Job is: \_\_\_\_\_

FAMILY HISTORY

Table with columns: Mom, Dad, Sibling, Grandparents, Aunt, Uncle and rows for various medical conditions like Alcoholism, Heart Disease, Depression/Suicide, Diabetes, High cholesterol, High blood pressure, Strokes, Bleeding Disorders, Asthma/COPD, and Other.

CHECK ANY OF THE CONDITIONS YOU HAVE HAD.

Anemia  Arthritis  Asthma  Blood clots  Chronic obstructive lung disease  Depression  Diabetes  Glaucoma  Hay Fever  Heart failure  Heart disease  High blood pressure  Kidney disease  Peptic ulcers  Reflux  Seizures  Stroke  Thyroid disease  Sexual Transmitted Diseases  Positive TB skin test  Other: \_\_\_\_\_

LIST ALL OPERATIONS WITH DATES

HAVE YOU BEEN HAVING THE FOLLOWING?

(Check the box)

Abdominal pain  Anxiety symptoms
 Bleeding tendency or excessive bruising
 Blood in stool or change in bowel movements
 Breast lump or nipple discharge  Change in vision
 Chest pain/tightness/discomfort  Cold or heat intolerant
 Concern about sexual function  Constipation
 Coughing up blood  Diarrhea  Difficulty urinating
 Discharge: vagina or penis  Dizziness
 Frequent urination  Headaches (frequent)
 Increased thirst or Appetite  Muscle or Joint pain
 Indigestion or heartburn
 Irregular heart beat (fast, skipped beats)  Insomnia
 Losing control of urine  Lost interest in things or feel hopeless
 Low back pain  Nausea or vomiting
 Neck pain  Persistent cough  Poor appetite
 Rash  Recent fevers/sweats  Shortness of breath
 Swollen legs or ankles  Trouble swallowing
 Unexplained weight loss or gain  Yellow Jaundice

WOMEN ONLY enter dates as (m/d/yyyy)

Age period began \_\_\_ Your last period? \_\_\_
How many pregnancies have you had? \_\_\_
How many deliveries? \_\_\_ Miscarriages? \_\_\_ Abortions? \_\_\_
Do you have irregular menses?  NO  YES
Do you have pelvic pain?  NO  YES

Physician Use Only (Comments)

Blank lines for physician comments.

Physician Use: \_\_\_\_\_