



## Adult Medical History Form

Please complete All **4** PAGES

Name \_\_\_\_\_

Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details.  
**Thank you!**

### PERSONAL INFORMATION:

Preferred name (if different from above): \_\_\_\_\_

What language would you prefer to use with us? \_\_\_\_\_

Address (if changed since your last visit to our practice, or if you are unsure that we have it):

Street \_\_\_\_\_ City/town; state; zip code \_\_\_\_\_

Home phone: \_\_\_\_\_; work phone \_\_\_\_\_; cell phone \_\_\_\_\_

What is the best way for our office to contact you? *Please circle one or more of above. If you prefer e-mail, please sign up for MyHealth, our secure e-mail site, and circle "MyHealth" on this line.*

Emergency contact: \_\_\_\_\_  
Name Relationship home phone work phone cell phone

### PRESENT HEALTH CONCERNS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MY HEALTH CARE GOALS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs; please continue additional medications on the other side of this page: ☐ I take no regular medications.

Medication	Dose	Times per day

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**ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:** ☐ I am not allergic to any medications.

Medication	Reaction or Side Effect

## PERSONAL MEDICAL HISTORY:

Do you have any of the following problems?

- |   |   |
|---|---|
| <input type="checkbox"/> Acid reflux (heartburn)                    | <input type="checkbox"/> Diabetes mellitus                  |
| <input type="checkbox"/> Alcoholism / other addiction               | <input type="checkbox"/> Erectile dysfunction               |
| <input type="checkbox"/> Allergies (environmental)                  | <input type="checkbox"/> Heart disease (specify type _____) |
| <input type="checkbox"/> Anxiety                                    | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Irritable bowel syndrome           |
| <input type="checkbox"/> Atrial fibrillation                        | <input type="checkbox"/> Migraines                          |
| <input type="checkbox"/> Cancer (specify type _____)                | <input type="checkbox"/> Osteopenia or Osteoporosis         |
| <input type="checkbox"/> Coagulation (bleeding or clotting) problem | <input type="checkbox"/> Prostate problem                   |
| <input type="checkbox"/> Cholesterol problem                        | <input type="checkbox"/> Thyroid problem                    |
| <input type="checkbox"/> Chronic low back pain                      | <input type="checkbox"/> Other problems (list below):       |
| <input type="checkbox"/> Depression                                 | <input type="checkbox"/> _____                              |

Have you ever had any of the following problems? If so, please provide approximate year:

Cancer of _____ please specify	Heart attack? _____	Blood transfusion? _____
	Stroke (CVA) _____	Seizure? _____

## SURGICAL HISTORY (Please list all prior operations and dates):

☐ I have had no prior surgery.

Operation	Date

Operation	Date

## FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

☐ I do not know my family history.

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, other skin							
Cancer, Ovary							
Cancer, Prostate							
Cancer (not noted)							
Colon Polyps							
Depression							
Diabetes, Type 1 (child)							
Diabetes, Type 2 (adult)							
Eczema							
Epilepsy (Seizures)							

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Genetic diseases							
Glaucoma							
Hay fever (Allergies)							
Hearing problems							
Heart Attack (CAD)							
High Blood Pressure							
High cholesterol							
Kidney diseases							
Lupus (SLE)							
Mental retardation							
Migraine headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke (CVA)							
Thyroid disorders							
Tuberculosis							
Other:							

## SOCIAL HISTORY

### SUBSTANCES:

#### Tobacco Use

Please check one:

☐ I have never smoked.

☐ I have smoked, but rarely.

When was the last time? \_\_\_\_\_

☐ I have quit smoking. Quit: Date \_\_\_\_\_

☐ I currently smoke \_\_\_\_\_ pack(s)/day, # of yrs. \_\_\_\_\_

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ No ☐ Yes

### SEXUALITY:

#### Sexual Activity

Sexually Active: ☐ Yes ☐ No ☐ Not currently

Current sex partner(s) is/are: ☐ male ☐ female

#### Contraception and Protection

Birth Control method: \_\_\_\_\_ ☐ None needed

If sexually active, do you practice safe sex? ☐ NA ☐ No ☐ Yes

Have you ever had any sexually transmitted diseases (STDs)?

☐ No ☐ Yes

If yes, please include: \_\_\_\_\_ date \_\_\_\_\_

Are you interested in being screened for sexually transmitted diseases? ☐ No ☐ Yes

Other concerns? \_\_\_\_\_

### SAFETY:

Do use seatbelts consistently? ☐ No ☐ Yes

Do you use a bike helmet regularly? ☐ NA ☐ No ☐ Yes

Is violence at home a concern for you? ☐ No ☐ Yes

Are you currently in a relationship? ☐ No ☐ Yes

If yes, do you feel safe in this relationship? ☐ No ☐ Yes

Do you have a gun in your home? ☐ No ☐ Yes

Other concerns? \_\_\_\_\_

### EXERCISE:

How active are you?

☐ I get a cardiovascular work-out 3 or more times/week.

☐ I walk daily but do not work out.

☐ I exercise or walk less than 3 times/week.

☐ I am not generally active.

☐ [other] \_\_\_\_\_

### Alcohol Use

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Regularly

Average# drinks/week: \_\_\_\_\_ 5 oz glasses wine;

\_\_\_\_\_ 12 oz cans beer; \_\_\_\_\_ 1.5 oz shots hard liquor

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

### PREFERRED PHARMACY:

\_\_\_\_\_ Include Address if not HVMA Pharmacy

### SOCIOECONOMICS:

**Ethnic Background:** How would you best describe yourself?

(check only one)

☐ Asian ☐ Black, Non-Hispanic ☐ Hispanic

☐ Native American ☐ Native Hawaiian & Other Pacific Islander

☐ White, Non-Hispanic ☐ Other ☐ Decline

**Marital status:** ☐ Single ☐ Married ☐ Sep ☐ Div ☐ Widow

☐ Co-habiting ☐ Engaged... ☐ Other: \_\_\_\_\_

Spouse/Partner's name: \_\_\_\_\_

**Number of children:** \_\_\_\_\_

**Who lives at home with you?** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Education completed:** ☐ Grade school ☐ High school

☐ College ☐ Graduate school

### EMOTIONS:

Over the past two weeks, how often have you been bothered by any of the following problems?

Please insert appropriate number for each question, using the following scale:

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

• Little interest or pleasure in doing things? \_\_\_\_\_

• Feeling down, depressed or hopeless? \_\_\_\_\_

**IMMUNIZATIONS:**

Please list your most recent immunizations. You do NOT need to include any immunizations given at Atrius Health. Please include your best estimate of the month and year of each immunization:

Hepatitis A \_\_\_\_\_

Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_

Pneumovax (Pneumonia) \_\_\_\_\_

Hepatitis B \_\_\_\_\_

MMR \_\_\_\_\_ Meningitis \_\_\_\_\_

Shingles \_\_\_\_\_

HPV \_\_\_\_\_

Varicella (chicken pox) shot \_\_\_\_\_

Other \_\_\_\_\_

Tetanus (Td) \_\_\_\_\_ Tdap \_\_\_\_\_

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

**Breasts**

\_\_\_\_ Breast pain/lump/discharge

**Constitutional**

\_\_\_\_ Fevers/chills/sweats

\_\_\_\_ Unexplained weight loss/gain?

\_\_\_\_ Fatigue/weakness

**Eyes**

\_\_\_\_ Change in vision

**Ears/Nose/Throat/Mouth**

\_\_\_\_ Difficult hearing

\_\_\_\_ Ringing in ears

\_\_\_\_ Problems with teeth/gums

\_\_\_\_ Hay fever/allergies

**Respiratory**

\_\_\_\_ Cough/wheeze

\_\_\_\_ Difficulty breathing

**Cardiovascular**

\_\_\_\_ Chest pain/discomfort

\_\_\_\_ Leg pain with exercise

\_\_\_\_ Palpitations

**Gastrointestinal**

\_\_\_\_ Abdominal pain

\_\_\_\_ Heartburn

\_\_\_\_ Bloody/black bowel movement

\_\_\_\_ Nausea/vomiting/diarrhea

\_\_\_\_ Constipation

\_\_\_\_ Change in bowel habits

**Genitourinary**

\_\_\_\_ Nighttime urination

\_\_\_\_ Difficulty starting urination

\_\_\_\_ Leaking urine

\_\_\_\_ Painful urination

\_\_\_\_ Blood in urine

\_\_\_\_ Discharge from penis

\_\_\_\_ Sexual function problems

**Musculoskeletal**

\_\_\_\_ Muscle/joint pain or swelling

**Neurological**

\_\_\_\_ Headaches

\_\_\_\_ Dizziness/light-headedness

\_\_\_\_ Numbness

\_\_\_\_ Memory loss

\_\_\_\_ Loss of coordination

**Psychiatric**

\_\_\_\_ Anxiety/stress

\_\_\_\_ Problems with sleep

\_\_\_\_ Depression

**Skin**

\_\_\_\_ Rash or mole change

\_\_\_\_ Itching

**Blood/Lymphatic**

\_\_\_\_ Unexplained lumps

\_\_\_\_ Easy bruising/bleeding

**Endocrine**

\_\_\_\_ Excessive thirst or urination

**Other** (please specify) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

☐ I have none of the above problems.