

Family Medicine Adult Health History

Appointment date _____

Name _____ Age _____ Birthdate _____

What is the reason for today's visit? (Please list all your concerns.) _____

MEDICAL HISTORY – Please mark (X) conditions that you have currently or have had in the past.

<p>Neurologic:</p> <p>◇ Headaches/Migraine</p> <p>◇ Seizures</p> <p>Eyes/Ears:</p> <p>◇ Cataracts</p> <p>◇ Glaucoma</p> <p>◇ Macular Degeneration</p> <p>◇ Glasses or Contacts</p> <p>◇ Other Eye Problems</p> <p>◇ Hearing Difficulty</p> <p>Skin & Allergies:</p> <p>◇ Acne</p> <p>◇ Chronic Rash</p> <p>◇ Allergies/Hay Fever</p> <p>◇ Hives</p> <p>Lungs:</p> <p>◇ Sleep Apnea</p> <p>◇ Asthma</p> <p>◇ Bronchitis/Pneumonia</p> <p>◇ Emphysema or COPD</p> <p>Cardiovascular:</p> <p>◇ High Cholesterol</p> <p style="padding-left: 20px;">Last Cholesterol _____</p> <p>◇ High Blood Pressure</p> <p>◇ Stroke</p> <p>◇ Heart Disease/Heart Attack</p> <p>◇ Heart Murmur</p> <p>Hematologic:</p> <p>◇ Anemia</p> <p>◇ Blood Clot</p> <p>◇ Blood Transfusion (Year _____)</p>	<p>Gastrointestinal:</p> <p>◇ Bowel Disease</p> <p>◇ Liver Disease</p> <p>◇ Stomach Ulcers/Acid Reflux</p> <p>◇ Constipation</p> <p>◇ Diarrhea</p> <p>Endocrine:</p> <p>◇ Diabetes</p> <p>◇ Thyroid Disease</p> <p>◇ Genetic Disease</p> <p>General:</p> <p>◇ Weight Problems</p> <p>◇ Muscle/Joint Disease</p> <p>◇ Osteoporosis</p> <p>◇ Insomnia</p> <p>◇ Cancer (Type _____)</p> <p>Mental Health:</p> <p>◇ Alcohol or Drug Dependency</p> <p>◇ Depression</p> <p>◇ Suicide Attempt</p> <p>◇ Psychiatric Care</p> <p>◇ Anxiety Disorder</p> <p>Genito-Urinary:</p> <p>◇ Kidney/Bladder Disease</p> <p>◇ Incontinence (Leaking of urine)</p> <p>◇ Difficulty with urination</p> <p>Infectious:</p> <p>◇ Tuberculosis</p> <p>◇ Hepatitis</p> <p>◇ HIV/AIDS</p> <p>◇ Sexually Transmitted Disease</p>	<p>Have you ever had a sexual relationship? _____</p> <p>Are you currently in a sexual relationship? _____</p> <p>Have your partners been:</p> <p>◇ Male ◇ Female ◇ Both</p> <p>Number of sexual partners in the last year? _____</p> <p><i>Women Only:</i></p> <p>◇ Currently Pregnant</p> <p>◇ Previous Abnormal Pap Smear</p> <p>◇ Menstrual Problems</p> <p>Last Period: _____</p> <p>Last Pap Smear: _____</p> <p>Last Mammogram: _____</p> <p>Last Bone Density: _____</p> <p>Number of Pregnancies: _____</p> <p>Number of Children: _____</p> <p><i>Men Only:</i></p> <p>◇ Prostate Disease</p> <p>◇ Erectile Problem/Impotence</p> <p>Last PSA _____</p> <p>Other Medical Problems:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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MAJOR ILLNESS/SURGERY – Please list any hospitalizations and/or surgeries you have had.

Date	Reason for Hospitalization or Surgery	Date	Reason for Hospitalization or Surgery

