Three Rivers
MEDICAL CLINIC

# Adult Medical History Form

Please complete all pages as entirely as possible. Answers will help providers understand medical concerns and conditions better.

_____ _____ Gender: □ Female □ Male

Patient Name Date of Birth

**CURRENT CONCERNS:**_____

**MEDICATIONS:** Include prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs.

| MEDICATION | DOSAGE | TIMES/DAY | DATE STARTED | CONDITION |
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**ALLERGIES or REACTIONS:** Include all responses and side effects to medications, foods, environments, etc.

| ALLERGEN / MEDICATION | REACTION or SIDE EFFECT |
|---|---|
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**SURGICAL HISTORY:** List operations and approximate dates.

| OPERATION | DATE |
|---|---|
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| | |

Patient: _____ Date of Birth: _____

**FAMILY HISTORY:** Indicate which family members have any of the following conditions.

| CONDITION | Self | Mother | Father | Sibling | Grandmother | Grandfather | Aunt | Uncle |
|---|---|---|---|---|---|---|---|---|
| **Abdominal Aortic Aneurysm** | | | | | | | | |
| **Abnormal Pap** | | | | | | | | |
| **Alcoholism** | | | | | | | | |
| **Anxiety** | | | | | | | | |
| **Arthritis/Lupus** | | | | | | | | |
| **Asthma** | | | | | | | | |
| **Atrial Fibrillation** | | | | | | | | |
| **Back Pain** | | | | | | | | |
| **Blood Transfusion** | | | | | | | | |
| **Blood Disorder**, Type: | | | | | | | | |
| **Cancer**, Breast | | | | | | | | |
| **Cancer**, Colon | | | | | | | | |
| **Cancer**, Ovarian | | | | | | | | |
| **Cancer**, Type: | | | | | | | | |
| **Chronic Pain**, Type: | | | | | | | | |
| **Colon Polyps** | | | | | | | | |
| **Crohn's Disease** | | | | | | | | |
| **Depression** | | | | | | | | |
| **Diabetes** | | | | | | | | |
| **Erectile Dysfunction** | | | | | | | | |
| **Hay Fever** | | | | | | | | |
| **Heart Disease** (include age at diagnosis) | | | | | | | | |
| **Heart Attack** | | | | | | | | |
| **High Cholesterol** | | | | | | | | |
| **High Blood Pressure** | | | | | | | | |
| **Irritable Bowel Syndrome** | | | | | | | | |
| **Kidney Disease** | | | | | | | | |
| **Liver Disease** | | | | | | | | |
| **Mental Illness**, Type: | | | | | | | | |
| **Migraines** | | | | | | | | |
| **Osteo- penia/porosis** | | | | | | | | |
| **Prostate Problems** | | | | | | | | |
| **Seizure** | | | | | | | | |
| **Scoliosis** | | | | | | | | |
| **Stroke** | | | | | | | | |
| **Substance Abuse** (Tobacco, Alcohol, Recreational Drugs) | | | | | | | | |
| **Thyroid Disorder/Disease** | | | | | | | | |
| **Ulcerative Colitis** | | | | | | | | |
| **Death Before Age 55** | | | | | | | | |
| **Other:** | | | | | | | | |

Patient: _____ Date of Birth: _____

## MEDICAL HISTORY:

What was the MONTH and YEAR of your last:

Bone Density: _____ □ Normal □ Abnormal □ Never

Colonoscopy: _____ □ Normal □ Abnormal □ Never

Eye Exam: _____ □ Normal □ Abnormal □ Never

Dental Exam: _____ □ Normal □ Abnormal □ Never

*Women only:*

Mammogram: _____ □ Normal □ Abnormal □ Never

Pap Smear Test: _____ □ Normal □ Abnormal □ Never

*If abnormal*, did you have a colposcopy? □ Yes □ No

*Men only:*

Prostate Exam: _____ □ Normal □ Abnormal □ Never

## SOCIAL HISTORY:

### SUBSTANCES

Tobacco Use: *I have*:

□ Never smoked □ Smoked, but rarely. When was the last time? _____

□ Smoked _____ pack(s) per day for _____ years. □ Quit smoking. Quit date: _____

Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew □ Dip □ Vapor

I am interested in quitting? □ Yes □ No *If yes*, when? □ Now □ 6 months □ 1 year or more

Alcohol Use:

Do you drink alcohol? □ Yes □ No What is the average number of drinks per week? _____

Is alcohol use a concern for you or others? □ Yes □ No

Drug Use:

Do you use any recreational drugs? □ Yes □ No

*If Yes*, which one(s)? _____

Have you ever used needles? □ Yes □ No

### EXERCISE

Activity: _____ Time/Duration: _____ minutes _____ days per week.

Exertion: □ Stroll □ Mild □ Heavy □ I am not generally active

### SEXUALITY

I am sexually active? □ Yes □ No □ Not currently

*If yes:* My sexual partner(s) is/are: □ Female □ Male □ Both Number of sexual partners: _____

Birth Control Method(s):_____

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

*If yes:* Which one(s)? _____

### SOCIOECONOMICS

Occupation: _____

Marital Status: □ Single □ Married □ Separated/Divorced □ Widowed □ Co-Habiting □ Engaged

Number of Children: _____ Number of People living at home with you: _____

Education Completed: □ High School □ GED □ College □ Graduate School