Adult Medical History Form
Please complete All 3 PAGES

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

PRESENT HEALTH CONCERNS:

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Times per Day</th>
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<th>Dose</th>
<th>Times per Day</th>
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ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>Reaction or Side Effect</th>
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<tbody>
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PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis)

- Congenital Heart Disease
  - Myocardial Infarction (Heart Attack)
  - Hypertension (High Blood Pressure)
  - Diabetes
  - High Cholesterol

- Stroke

- Thyroid Problem

- Coagulation disorder

- Cancer (Malignancy)

- Depression/suicide attempt

- Alcoholism

- If you have ever had a blood transfusion, please specify date

- Abnormal Pap Smear

- Other Problems

- If you have had a Colonoscopy, What date:

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

<table>
<thead>
<tr>
<th>Operation</th>
<th>Date</th>
<th>Operation</th>
<th>Date</th>
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WOMEN'S GYNECOLOGIC HISTORY:
For Women: # of pregnancies: ___ # of deliveries: ___ # of abortions: ___ # of miscarriages: ___
1st day, most recent period: ______ Age at 1st period: ______ Frequency of periods: ______ Length of each: ______
Do you have any concerns about your periods? □ No □ Yes: _____________________________________________
Do you have any concerns about menopause? □ No □ Yes: ______________________________________________

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

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Mom</th>
<th>Dad</th>
<th>Sis</th>
<th>Bro</th>
<th>Daug</th>
<th>Son</th>
<th>Other</th>
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<tbody>
<tr>
<td>Alcoholism</td>
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<td>Anemia</td>
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<td>Anesthesia problem</td>
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<td>Arthritis</td>
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<td>Asthma</td>
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<td>Birth Defects</td>
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<td>Bleeding problem</td>
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<td>Cancer, Breast</td>
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<td>Cancer, Colon</td>
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<td>Cancer, Melanoma</td>
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<td>Cancer, Skin (except melanoma)</td>
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<td>Cancer, Ovary</td>
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<td>Cancer, Prostate</td>
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<td>Cancer (not noted)</td>
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<td>Depression</td>
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<td>Diabetes, Type 1 (childhood onset)</td>
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<td>Diabetes, Type 2 (adult onset)</td>
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<td>Eczema</td>
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<td>Epilepsy (seizures)</td>
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<tr>
<th>Medical Condition</th>
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<td>Genetic Diseases</td>
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<td>Glaucoma</td>
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<td>Hay fever (allergic Rhinitis)</td>
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<td>Hearing problems</td>
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<td>Heart Attack (Coronary Artery Disease)</td>
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<td>High Blood Pressure (Hypertension)</td>
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<td>High Cholesterol (Hyperlipidemia)</td>
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<td>Kidney Disease</td>
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<td>Lupus (Systemic Lupus Erythematosis)</td>
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<td>Mental Retardation</td>
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<td>Migraine Headaches</td>
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<td>Mitral Valve Prolapse</td>
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<td>Osteoarthritis</td>
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<td>Osteoporosis</td>
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<td>Rheumatoid Arthritis</td>
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<td>Stroke</td>
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<td>Thyroid Disorders</td>
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<td>Tuberculosis</td>
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SOCIAL HISTORY
Tobacco Abuse
Cigarettes
Quit: Date ______
Never
Current/Smoker: packs/day____ # of years ______
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □Yes □ No

Alcohol Use
Do you drink alcohol? □ No □ Yes/# of drinks/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 exercise regularly? □ No □ Yes
SOCIOECONOMICS
Occupation: ____________________________________________
Education completed: ☐ Grade school ☐ High School
☐ College ☐ Graduate School
Years of education __________
Marital Status: ☐ Single ☐ M ☐ Sep ☐ D ☐ W ☐ Co-habiting
☐ Engaged… ☐ Other: ______________________________
Spouse/Partner's name: _____________________________
Number of children: ____________________________
Who lives at home with you? _________________________

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 (STD's)? ☐ No ☐ Yes
If yes, please include:
__________________ date_______
__________________ date_______

IMMUNIZATIONS:
Please list your most recent immunizations. You do NOT need to include any immunizations given at Stonecreek Family Physicians. Please include your best estimate of the month and year of each immunization:
Hepatitis A ____ Measles____ Mumps____ Rubella____ Pneumovax(pneumonia)____
Hepatitis B ____ MMR____
Tetanus TD ____ Varicella(chicken pox)____ Other____

REVIEW OF SYSTEMS: Please check (√) any current problems you have on the list below.
Constitutional
☐ FEVERS/chills/sweats
☐ Unexplained weight loss/gain
☐ Fatigue/weakness
☐ Excessive thirst or urination
☐ Change in vision
Ears/Nose/Throat/Mouth
☐ Difficult hearing/ringing in ears
☐ Problem with teeth/gums
☐ Hay fever/allergies
☐ Chest pain/discomfort
☐ Leg pain with exercise
☐ Palpitations
☐ Breast lump/discharge
☐ Cough/wheeze
☐ Difficulty Breathing
☐ Abdominal pain
☐ Blood in bowel movement
☐ Nausea/vomiting/diarrhea
☐ Nighttime urination
☐ Leaking urine
☐ Unusual vaginal bleeding
☐ Discharge: penis or vagina
☐ Sexual function problems
☐ Muscle/joint pain
☐ Rash or mole change
☐ Headaches
☐ Dizziness/light-headedness
☐ Numbness
☐ Memory loss
☐ Loss of coordination
☐ Anxiety/stress
☐ Problems with sleep
☐ Depression
☐ Unexplained lumps
☐ Easy bruising/bleeding
☐ Other (please specify)_______________________

Emotions:
1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest and pleasure in things that you usually cared about or enjoyed? ☐ No ☐ Yes
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? ☐ No ☐ Yes
3. Have you felt depressed or sad much of the time in the past year? ☐ No ☐ Yes

Are you interested in being screened for sexually transmitted diseases? ☐ No ☐ Yes
Other concerns? ____________________________________
__________________ date_______
__________________ date_______

Other concerns? ____________________________________
__________________ date_______
__________________ date_______

SAFETY
Do you use seatbelts consistently? ☐ No ☐ Yes
Do you use a bike helmet regularly? ☐ No ☐ Yes
Is violence at home a concern for you? ☐ No ☐ Yes
Do you feel safe in your current relationship? ☐ No ☐ Yes
Do you have a gun in your home? ☐ No ☐ Yes
Other concerns? ____________________________________
__________________ date_______
__________________ date_______

Other concerns? ____________________________________
__________________ date_______
__________________ date_______

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