

Confidential Adult Medical History Form

Last Name: _____ First Name: _____ Middle: _____

Names of other doctors: _____

Age: _____ Sex: _____ Birthdate: ___/___/___ Occupation/Employer: _____

Religious preference (if it has implications on your health and care): _____

Marital status (circle): Single Married Divorced Widowed Other

Do you have **Allergies** to any medications, foods, insect stings, x-ray contrast dye, or other? _____ Yes _____ No
If yes, please describe:

Please list all Medications, vitamins, and herbal supplements:

Please list any Health Problems, Surgeries or Hospitalizations:

Do you use tobacco products? _____ Yes _____ No If yes, how much: _____

Do you drink alcohol? _____ Yes _____ No If yes, how much: _____

Do you use any illegal drugs? _____ Yes _____ No If yes, what type, how much, and how often: _____

Family History of Medical Problems:

Father: _____

Mother: _____

Siblings: _____

Immunizations (please complete as applicable):

Date of last tetanus _____ ___ Unsure

Date of last TB test _____ ___ Unsure

Flu Shot _____ ___ Unsure

Pneumovax _____ ___ Unsure

Hepatitis A series _____ Yes _____ No _____ Unsure Hepatitis B series _____ Yes _____ No _____ Unsure

Last General Physical exam: _____ Last Sigmoidoscopy, if applicable: _____

Last Cholesterol check: _____ Results: _____ Normal _____ Abnormal

Females Only: Current method of birth control: _____

Total number of pregnancies: _____ Live births: _____ Miscarriages/abortions: _____

Last Mammogram? _____ Last Pap Smear? _____

Males Only: Any urination or prostate problems? _____ If so, what? _____

Have you had a vasectomy? _____ Have you had a PSA, if indicated? _____

PATIENT SIGNATURE

DATE

PROVIDER SIGNATURE

DATE