Patient History Form: Adult (18 & over)-Complete

Please fill out this form completely to provide your physician with information

Name_______________________________________

Occupation_________________________________

Marital Status______________________________

Spouses Name______________________________

Spouses Occupation__________________________

Children in the home_________________________

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1. Do you see any specialists? If yes, list name and specialty.

2. List any Surgeries, accidents, or injuries you have had.

3. List all prescriptions and over the counter medications you currently take.

4. Have you ever had a reaction or allergy to any medications? If **YES,** name med and reaction.

5. Please **CIRCLE** if anyone in your family has had….

High Blood Pressure	Stroke	Diabetes
High Cholesterol	Cancer	Depression
Heart Disease	Other_______________	

6. List any Medical Problems or Diseases you have had.

7. What problems/concerns do you have reguarding your health?

8. Please circle the following answers.

Do you….

Smoke/ chew tobacco	Y	N	Quit (date)_________
Drink caffeine (cof/pop/tea)	Y	N	Amt_______________
Drink alcohol	Y	N	Amt_______________
Wear seatbelts	Y	N	Sometimes
Wear sunscreen	Y	N	Sometimes
Exercise	Y	N	Amt_______________
Eat Fruit & Vegetables	Y	N	Amt_______________
Need help dressing	Y	N	Sometimes
Use a cane or walker	Y	N	Sometimes
Keep track of your own medicines	Y	N	
Drive a car?	Y	N	

9. Please **CIRCLE** any problems you have in the last WEEK.

Fevers	Urinary Incontinence
Night Sweats	Problems in Urine Flow
	Vaginal Bleeding
Weight Changes	Skin Growths
Blurred Vision	Falling
Trouble Hearing	Headaches
Chest Pain/Discomfort	Fainting
Swelling in Feet	Forgetfulness
Cough	Confusion
Difficulty Breathing	Others worried about your memory
Abdominal Pain	
Decreased Appetite	Depression
Difficulty Swallowing	Mood Swings
Constipation	Thought of Suicide
Blood in stool	Hopeless Feelings
Vomiting	Loss of interest in things
Change in Stools	

10. When was your last?

Annual Physical______________

Mammogram_______________