Adult Medical History

Date: _____ Referred by: _____

Name: _____ Sex: M or F Marital Status: _____

Birthdate: _____ Occupation: _____

Please list any current medical problems or concerns:

_____

_____

Past Medical Illnesses:

_____

_____

_____

Previous Surgeries or Hospitalizations:

_____

_____

_____

Medications:

_____

_____

_____

_____

_____

Allergies:

_____

Personal History	**Yes**	**No**	**How Much**
Do you smoke?	____	____	_____
Do you drink alcohol?	____	____	_____
Do you use illegal drugs?	____	____	_____
Do you consume caffeine? (ex: coffee, tea, pop)	____	____	_____

Family History- Please check any condition present in your blood relatives and then list how they are related to you.

		List the family member
Cancer	____	_____
Diabetes	____	_____
High Blood Pressure	____	_____
Heart Disease	____	_____
Stroke	____	_____
Asthma	____	_____
Thyroid Disease	____	_____
Other: _____	____	_____

PLEASE TURN OVER PAGE AND COMPLETE !

Please check any of the listed if apply to you at the current time.

Headaches:
- Seizures/fainting spells ____
- Numbness/Paralysis ____
- Dizziness ____
- Tremors/Shakes ____

Eyes, Ears, Nose, Throat:
- Change in vision ____
- Ear Trouble ____
- Change in Voice ____

Cardiac & Respiratory:
- Chest Pain/Pressure ____
- Chronic Cough ____
- Coughing up blood ____
- Shortness of breath ____
- Palpitations ____
- Ankle Swelling ____

Gastrointestinal:
- Abdominal Pain ____
- Heartburn/Indigestion ____
- Change in bowel habits ____
- Rectal bleeding ____
- Trouble Swallowing ____
- Loss of Appetite ____
- Vomiting ____

Genitourinary:
- Frequency of urination ____
- Burning sensation ____
- Difficulty/Change in stream ____
- Blood in urine ____
- Chronic bladder infections ____
- Prostate problems ____

Menstrual:
- Age at onset ____
- Are your cycles regular? ____
- Avg # of days bleeding ____
- Number of pregnancies ____
- Number of births ____
- # of miscarriages/abortions ____

Metabolic:
- Loss/Gain in weight ____
- Unexplained fatigue ____
- Goiter/Thyroid trouble ____

Skin:
- Changes in moles ____
- Sores or rashes ____
- Easy bruising ____

Psychiatric:
- Trouble Sleeping ____
- Nervousness/anxiety ____
- Depression ____

Sexual:
- Type of contraception ____
- Number of partners ____

Musculoskeletal:
- Back Pain/Injury ____
- Painful Swollen Joints ____
- Muscle Weakness ____
- Muscle Soreness ____