ADULT HISTORY AND REVIEW

Please fill out the following form so we may best serve your healthcare needs. This information is strictly confidential and will become part of your personal record. Please be as complete as possible.

Patient Name _____ SSN _____ Date of Birth _____

PAST MEDICAL HISTORY

List all past and current medical problems and please include dates.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PAST SURGICAL HISTORY

Please list all past surgeries and dates.

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES

Please list all drug, food, and environmental allergies, as well as reaction.

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS

Please list all prescription medications and over the counter medications, as well as vitamins, with the dosage and how often they are taken.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PHARMACY_____

DATE OF EXAM _____

SOCIAL HISTORY

1. Highest level of education _____
2. Have you ever smoked or used tobacco? _____
   If so, how much? _____
3. Do you drink alcohol? _____
   If so, how much? _____
4. Have you ever used illicit drugs? _____
   If so, what kind? _____
5. Marital Status: M S W D
6. Occupation _____
7. Children (name(s)/year of birth)
   _____
   _____
   _____
8. Spouse (name/year of birth)
   _____
9. Pets _____
   Indoor/outdoor? _____
10. Sexual preference _____
11. Have you ever received a blood transfusion?
    _____ If yes, what year? _____
12. Date of last tetanus injection _____
13. Have you ever had a colonoscopy? _____
    If yes, when? _____
14. Females, last menstrual period _____

FAMILY HISTORY

Please list family members (1st degree relatives only: such as mom, dad, siblings, children) with a history of any of the following:

Diabetes _____
High blood pressure _____
Obesity _____
High Cholesterol _____
Stroke _____
Heart Attacks _____
Seizures _____
Thyroid problems _____
Lung Problems _____
Alcoholism _____
Tuberculosis_____
Mental problems _____
Blood disorders _____
Kidney problems _____
Skin problems _____
Cancer (what type?) _____