

## Adult Medical History Form

PLEASE COMPLETE ALL 3 PAGES

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_ Email: \_\_\_\_\_

How would you rate your general health?  Excellent  Good  Fair  Poor

### PRESENT HEALTH CONCERNS:

\_\_\_\_\_  
\_\_\_\_\_

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

Medication Dose (eg. mg/pill) How many times per day When started

\_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES or REACTIONS TO MEDICINES:

\_\_\_\_\_  
When were your most recent **IMMUNIZATIONS:**

Hepatitis A \_\_\_ Hepatitis B \_\_\_ Influenza (Flu Shot) \_\_\_ Measles \_\_\_ Pneumovax (Pneumonia) \_\_\_

Rubella \_\_\_ Tetanus (Td) \_\_\_ Varicella (chicken pox) shot \_\_\_ or Illness \_\_\_

When were your most recent **HEALTH MAINTENANCE** screening tests:

Lipid (Cholesterol Screening) \_\_\_ Results? \_\_\_\_\_

Mammogram \_\_\_ Results? \_\_\_\_\_

Ever abnormal? \_\_\_ Details: \_\_\_\_\_

Pap Smear \_\_\_ Results? \_\_\_\_\_

Ever abnormal? \_\_\_ Details: \_\_\_\_\_

HIV \_\_\_ Results? \_\_\_\_\_

Hepatitis C? \_\_\_ Results? \_\_\_\_\_

Liver Panel? \_\_\_ Results? \_\_\_\_\_

### PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with dates):

\_\_\_ Heart disease:

specify type \_\_\_\_\_

\_\_\_ High blood pressure

\_\_\_ High cholesterol

specify type \_\_\_\_\_

\_\_\_ Blood transfusion

\_\_\_ Cancer (Malignancy)

specify type \_\_\_\_\_

\_\_\_ Heart attack

\_\_\_ Diabetes

\_\_\_ Thyroid problem

\_\_\_ Bleeding/clotting problem

\_\_\_ Suicide attempt

\_\_\_ Stroke

\_\_\_ Alcoholism

Other problems (specify):

## SOCIAL HISTORY

### Substance & Sexuality

#### Tobacco Use

Cigarettes  Never  Quit: Date \_\_\_\_\_

Current: Smoker: packs/day \_\_\_\_\_ # of yrs \_\_\_\_\_

Other Tobacco:  Pipe  Cigar  Snuff  Chew

Are you interested in quitting?  No  Yes

#### Alcohol Use

Do you drink alcohol?  No  Yes: # 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

Are you under the influence of intoxicating substances right now?  No  Yes:

#### Sexual Activity

Sexually Active:  Yes  No  Not currently

Current sex partner(s) is/are:  male  female

Birth control method: \_\_\_\_\_  None needed

Have you ever had any sexually transmitted diseases

(STDs)?  No  Yes

#### Other Concerns

**CAFFEINE Intake:**  None  Coffee/tea: \_\_\_\_\_ cups/day

Sodas: \_\_\_\_\_ /day  Chocolate: \_\_\_\_\_ oz./day

**WEIGHT:** Are you satisfied with your weight?  No  Yes

**DIET:** How do you rate your diet?  Good  Fair  Poor

**EXERCISE:** Do you exercise regularly?  No  Yes

What kind of exercise? \_\_\_\_\_

How long (minutes) \_\_\_\_\_ How often? \_\_\_\_\_

Have you had acupuncture before?  No  Yes If yes, when and where? \_\_\_\_\_

Have you had massage/bodywork before?  No  Yes

**Socioeconomics** Occupation: \_\_\_\_\_

Employer \_\_\_\_\_

Years of Education/Highest Degree \_\_\_\_\_ Marital Status:  S  M  D  W  Other:

Spouse/Partner's name: \_\_\_\_\_ Number of children/ages:

Who lives at home with you?

**SPECIALTY HISTORY:** For women: # pregnancies: \_\_\_\_\_ # deliveries: \_\_\_\_\_ # abortions:

\_\_\_\_\_ # miscarriages: \_\_\_\_\_

1st day, most recent period: \_\_\_\_\_ Age at 1st period: \_\_\_\_\_ Frequency of periods: \_\_\_\_\_

Length of each: \_\_\_\_\_

Are you currently pregnant?  No  Yes:

Do you have any concerns about your periods?  No  Yes:

Do you have any concerns about menopause?  No  Yes:

**REVIEW OF SYMPTOMS:** Please check ( ✓ ) any current problems you have on the list below:

**Constitutional**

- Fevers/chills/sweats
- Change in energy/weakness
- Unexplained weight loss/gain
- Excessive thirst or urination

**Eyes**

- Change in vision

**Ears/Nose/Throat/Mouth**

- Difficult hearing/ringing in ears
- Problems with teeth/gums
- Hay fever/allergies

**Chest (breast)**

- Breast lump/nipple discharge

**Gastrointestinal**

- Abdominal pain
- Blood in bowel movement
- Nausea/vomiting/diarrhea

**Genitourinary**

- Nighttime urination
- Leaking urine
- Unusual vaginal bleeding
- Discharge: penis or vagina

**Skin**

- Rash/mole change

**Neurological**

- Headaches
- Dizziness/light-headedness
- Numbness
- Memory loss
- Loss of coordination

**Sexual, reproductive**

- Problems with sexual function
- Other, explain

**Psychiatric**

- Anxiety/stress
- Problems with sleep
- Depression

**Cardiovascular**

- Chest pain/discomfort
- Palpitations

**Respiratory**

- Cough/wheeze
- Difficulty breathing

**Blood/Lymphatic**

- Unexplained lumps
- Easy bruising/bleeding

**Musculo-skeletal**

- Muscle/joint pain

Describe the quality of the pain as best you can. Is it Constant? Intermittent Sharp? Burning? Dull? ...etc. Mark the location of the pain on the diagrams, and indicate the quality of pain at the location.

