VALLEY MEDICAL CENTER
Adult Medical History Form

NAME: _____D.O.B._____

EMAIL:_____

Your answers on this form will help your clinician 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!

PRESENT HEALTH CONCERNS:

_____
_____
_____

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

MEDICATIONS	DOSE AND TIME PER DAY

ALLERGIES or REACTION TO MEDICINES/FOOD/OTHER AGENTS

MEDICATION	REACTION or SIDE EFFECT

PERSONAL MEDICAL HISTORY

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

___Congenital Heart disease:
specify type
_____
___Myocardial Infarction (Heart attack)
___Hypertension (High Blood Pressure)
___Diabetes
___High Cholesterol
___Stroke
___Thyroid problem
specify type
_____
___Coagulation (bleeding/clotting) disorder
___Cancer (Malignancy)
specify type
_____
___Depression/suicide attempt
___Alcoholism
___If you have ever had a blood transfusion, please specify date
___Abnormal Pap smear
Other
_____
When was your last Tetanus shot?
_____

SURGICAL HISTORY (Please list all prior operations and dates):

OPERATION	DATE

SOCIAL HISTORY

SUBSTANCES
Tobacco Use
Cigarettes
Quit: Date_____
___Never
____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
EXERCISE
Do you exercise regularly? ____No ____Yes

SOCIOECONOMICS:

Occupation: _____
Education completed: __Grade school __High school __College __Graduate school
Years of Education___
Marital status: __Single __M __Sep __D __W
Spouse/Partner's name:_____
Number of children: _____
Who lives at home with you?_____

Are you interested in being screened for sexually transmitted diseases? ___ Yes or ___ No
Other concerns?_____
_____

SAFETY:

Do use seat belts consistently? ___No ___Yes
Do you a bike helmet regularly? ___No ___Yes
Is violence at home a concern for you? __No __Yes
Do you feel safe in your current relationship? __No __Yes
Do you have a gun in your home? ___No ___Yes
Other concerns?_____

SEXUALITY

Sexual Activity
Sexually Active: ___Yes __No
Current sex partner(s) is/are: Male Female
Contraception and Protection
Birth Control method:_____
If sexually active, do you practice safe sex? __NA __No __Yes
Have you ever had any sexually transmitted diseases (STDs)? ____No ____Yes
If yes, please include: _____
_____
_____

EMOTIONS:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? ____No ____Yes
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? ___No ___Yes
3. Have you felt depressed or sad most of the time in the past year? ___No ___Yes

IMMUNIZATIONS

Please list your most recent immunizations. Please include your best estimate of the month and year of each immunization:

Hepatitis A_____ Measles_____ Mumps_____ Rubella_____ Pneumonia_____
Hepatitis B_____ MMR_____ Tetanus (Td)_____ Varicella (chicken pox) shot _____
Other_____

REVIEW OF SYSTEMS: Please check any current problems you have on the list below.

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Fatigue/weakness
___Excessive thirst or urination

Eyes
___Change in vision

Ear/Nose/Throat/Mouth
___Difficult hearing/ringing in ears
___Problems with teeth/gums
___Hay fever/allergies

Cardiovascular
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations

Chest (breast)
___Breast lumps/discharge

Respiratory
___Cough/wheeze
___ Difficulty breathing

Gastrointestinal
___Abdominal pain
___Blood in bowel movement
___Nausea/vomiting/diarrhea

Genitourinary
___Nighttime urination
___Leaking urine
___Unusual vaginal bleeding
___Discharge: penis or vagina
___Sexual function problems

Musculo-skeletal
___Muscle/joint pain

Skin
___Rash or mole change

Neurological
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination

Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression

Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding

*Other(please specify)*_____
_____

WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies:___ #deliveries:___ #abortion:___ #miscarriages:___
1st day, most recent period:_____ Age at 1st period:_____ Frequency of periods:_____ Length of each:_____
Do you have any concerns about your periods? _____No _____Yes:_____
Do you have any concerns about menopause? _____No _____Yes:_____

FAMILY HISTORY

Please indicate with a check family members who have had any of the following conditions:

MEDICAL CONDITION	MOM	DAD	SIST.	BRO.	DAUG	SON	OTHER
ALCOHOLISM							
ANEMIA							
ANESTHESIA PROBLEM							
ARTHRITIS							
ASTHMA							
BIRTH DEFECTS							
BLEEDING PROBLEM							
CANCER, BREAST							
CANCER, COLON							
CANCER, MELANOMA							
CANCER, SKIN							

CANCER, OVARY							
CANCER, PROSTATE							
CANCER (not noted)							
DEPRESSION							
DIABETES, TYPE 1							
DIABETES, TYPE 2							
ECZEMA							
EPILEPSY (SEIZURES)							
GENETICS DISEASES							
GLAUCOMA							
HAY FEVER (ALLERGIC RHINITIS)							
HEARING PROBLEMS							
HEART ATTACK (CORONARY ARTERY DISEASE)							
HIGH BLOOD PRESSURE (HYPERTENSION)							
HIGH CHOLESTEROL (HYPERLIPIDEMIA)							
KIDNEY DISEASES							
LUPUS (SYSTEMIC LUPUS ERYTHEMATOSIS)							
MENTAL RETARDATION							
MIGRAINE HEADACHES							
MITRAL VALUE PROLAPSE							
OSTEOARTHRITIS							
OSTEOPOROSIS							
RHEUMATOID ARTHRITIS							
STROKE							
THYROID DISORDERS							
TUBERCULOSIS							
OTHER:							