Shah and Associates Family Practice _____

Name *Date*

Adult Medical History Form

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

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

Main reason for today's visit: _____

Other concerns I would like to discuss if there is time: _____

REVIEW OF SYMPTOMS: Please check (✓) any CURRENT symptoms you have.

Constitutional
___ Fever/sweats/weakness
___ Unexplained weight loss/gain

Eyes
___ Change in vision

Ear/Nose/Throat/Mouth
___ Difficulty hearing/ringing in ears
___ Hay fever/allergies

Cardiovascular
___ Chest pain/discomfort
___ Palpitations

Breast
___ Breast lump/nipple discharge

Respiratory
___ Cough/wheeze

Gastrointestinal
___ Blood in bowel movement
___ Nausea/vomiting/diarrhea

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

Musculoskeletal
___ Muscle/joint pain

Skin
___ Rash/new or change in mole

Neurological
___ Headaches
___ Memory loss

Psychiatric
___ Anxiety/stress
___ Sleep problem
___ Depression

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

Other
___ Concern with sexual function

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ◯ Yes ◯ No

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

Medication	Dose (e.g., mg/pill)	How many times per day

ALLERGIES or REACTIONS TO MEDICINES: _____

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ Measles _____ Pneumovax (pneumonia) _____
Rubella _____ Tetanus (Td) _____ Varicella (chicken pox) shot or illness _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol): _____ Date _____ Abnormal? ◯ Yes ◯ No
Sigmoidoscopy ____ or Colonoscopy _____ Date _____ Abnormal? ◯ Yes ◯ No
Women: Mammogram ___ Date _____ Abnormal? ◯ Yes ◯ No Pap smear ___ Date _____ Abnormal? ◯ Yes ◯ No
Men: PSA (prostate) _____ Date _____ Abnormal? ◯ Yes ◯ No

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

___ Heart disease:
specify type _____
___ Heart attack (412)
___ High blood pressure
___ Diabetes
___ Other (specify): _____
___ High cholesterol
___ Thyroid problem

SURGICAL HISTORY: Please list all prior operations (with dates).

_____

FAMILY HISTORY: Please indicate the current status of your immediate family members: _____

Please indicate family members (parent, sibling, grandparent, aunt, or uncle) with any of the following conditions:

Alcoholism _____
Cancer, specify type _____
Heart Attack _____
Depression/Suicide _____
Diabetes _____
High Cholesterol _____
High Blood Pressure _____
Stroke _____
Other: _____
Other: _____

SOCIAL HISTORY

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 your 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 to inject drugs? ◯ No ◯ Yes

Sexual Activity

Sexually active: ◯ No ◯ Yes ◯ 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
Are you interested in being screened for sexually transmitted diseases? ◯ No ◯ Yes

Other Concerns

CAFFEINE Intake: ◯ None ◯ Coffee/tea/soda _____ cups/day
WEIGHT: Are you satisfied with your weight? ◯ No ◯ Yes
DIET: How do you rate your diet? ◯ Good ◯ Fair ◯ Poor
Do you eat or drink 4 servings of dairy or soy daily or take calcium supplements? ◯ No ◯ Yes
EXERCISE: Do you exercise regularly? ◯ No ◯ Yes
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____
SAFETY: Do you use a bike helmet? ◯ No ◯ Yes ◯ NA
Do you use seatbelts consistently? ◯ No ◯ Yes
Is VIOLENCE at home a concern for you? ◯ No ◯ Yes
Have you ever been ABUSED? ◯ No ◯ Yes
Do you have a GUN in your home? ◯ No ◯ Yes

SOCIOECONOMICS: Occupation: _____ Employer: _____
Years of education/highest degree: _____
Marital Status: ◯ Single ◯ Partner/Married ◯ Divorced ◯ Widowed ◯ Other: _____
Spouse/partner's name: _____ Number of children/ages: _____
Who lives at home with you? _____

WOMEN'S HEALTH HISTORY: # pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____
1st day of most recent period: _____