Associates in Family Medicine

Patient History Form (Adult)

Patient Name_____ DOB_____ Today's Date_____

Person(s) to contact in an emergency_____

Relationship_____ Phone numbers_____

Who lives in your household?_____

Are they in good health?_____

Have you made a Living Will or put your Health Care wishes IN WRITING? Yes No

(If yes, please bring a copy to your appointment.)

MEDICAL HISTORY

Please list any chronic medical conditions you have been or currently are being treated for (ex. high blood pressure, diabetes, anxiety, depression):

_____

_____

_____

Please list any medications you are currently taking and bring them to your appointment. Please include strength and frequency.

Medication	Strength (mg.)	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any medication allergies? Yes No
Please list name of drug and type of reaction:

Do you have a latex allergy? Yes No

(CONTINUED)

Please list surgical procedures you have had in the past:

_____

Do you currently or have you ever done the following (check all that apply):

____Smoke cigarettes or pipe. If yes, how many per day?_____

____Use smokeless tobacco. If yes, how many times per day?_____

____Vaping: ____with nicotine ____without nicotine

____Drink alcohol. If yes, how many ____drinks per day / week / month

____Use recreational drugs or prescription drugs prescribed for someone else? If yes, how many times per week and what type?_____

____Exercise regularly? If yes, how many times per week?_____

____Sexually active If yes: ___Heterosexual ___Same sex ___Bisexual

____ Practice safe sex

Employment ___Full-time ___Part-time ___Retired ___Not working

Occupation_____

Were you born or do you live outside of the United States? _____

Please list all physicians you have seen in the past 5 years:

_____

_____

_____

_____

Have you had:

Influenza vaccine	No	Yes	Year_____	Zostavax (Shingles) vaccine			
Tetanus vaccine	No	Yes	Year_____	(over age 60)	No	Yes	Year_____
Adacel (Tdap) vaccine	No	Yes	Year_____	Chickenpox:			
Pneumococcal vaccine	No	Yes	Year_____	___ Disease	Year_____		
				___ Vaccine	Year _____		

(CONTINUED)

FAMILY HISTORY:

Please place a check mark if any family members have had the following medical problems. Please write in space below if additional room is needed: M = Maternal (mother's side) P = Paternal (father's side)

	Father	Mother	Grand-father		Grand-mother		Sister	Brother	Aunt		Uncle		Daughter	Son
			M	P	M	P			M	P	M	P		
Deceased														
Diabetes														
High Blood Pressure														
Heart Disease														
Stroke														
Kidney Disease														
Obesity														
Genetic Disorder														
Alcoholism														
Liver Disease														
Depression														
Colon or rectal cancer														
Breast cancer														
Other cancer														
Other_____														

Do you have problems with (check all that apply):

____Bleeding disorder
____General weakness
____Difficulty with vision
____Difficulty hearing
____Mouth or dental problems
____Severe headaches
____Changing moles
____Shortness of breath
____Chest pains
____Palpitations
____Joint pains
____Heart murmur
____Frequent cough
____Change in weight
____Change in appetite
____Indigestion/heartburn
____Urine incontinence or leakage
____Nausea/vomiting
____Bowel habit change
____Rectal bleeding
____Handicap
____Often depressed
____Cry easily
____Overly anxious
____Sexual concerns
____Falling

WOMEN ONLY:

Last menstrual period_____ Number of child births_____ Number of pregnancies_____

Date of last mammogram_____ Date of last pap smear_____

Date of last colonoscopy_____ Who performed by_____

Do you have any concerns?_____

MEN ONLY:

Do you have any concerns?_____

Date of last colonoscopy_____ Who performed by_____

Thank you for choosing Associates in Family Medicine services and completing this important health history form. This information will help your doctor provide the best care for you.

2/2016