ABClinic Family Cares Inc
ADULT Medical History Information

(18 and older)

Name ____ Date of Birth __________________ Age _______

Address ____ City _______________ State _________ Zip _________

Sex: ______Male ______Female Home phone_________ Cell phone _________ Work phone _________Email ______________

Pharmacy Name ____ Pharmacy #(_____)__________________________

REVIEW OF SYSTEMS (Please answer if you are having any of these symptoms CURRENTLY):

General: ☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Weakness ☐ Awakening feeling unrefreshed
Skin: ☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness ☐ Color changes ☐ Hair or nail changes
Head: ☐ Headache ☐ Head injury
Ears: ☐ Decreased hearing ☐ Ringing in ears ☐ Earache ☐ Drainage
Eyes: ☐ Visual change _______ ☐ Glasses or contacts ☐ Eye pain ☐ Redness ☐ Blurry or double vision ☐ Flashing lights
Nose: ☐ Stuffiness ☐ Discharge ☐ Itching ☐ Hay fever ☐ Nosebleeds ☐ Sinus pain
Throat/Mouth: ☐ Tooth problems ☐ Sore tongue ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush
Neck: ☐ Lumps ☐ Swollen glands ☐ Pain ☐ Stiffness
Breasts: ☐ Lumps ☐ Discharge ☐ Pain
Respiratory: ☐ Cough (dry or productive)? ☐ Sputum color _____ ☐ Coughing up blood ☐ Wheezing ☐ Shortness of breath ☐ Alcoholism
Cardiovascular: ☐ Chest pain or discomfort ☐ Chest tightness ☐ Palpitations ☐ Shortness of breath with activity ☐ Difficulty breathing lying down ☐ Swelling (edema) ☐ Sudden awakening from sleep with shortness of breath
Gastrointestinal: ☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea ☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea ☐ Vomiting
Urinary: ☐ Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine ☐ Incontinence ☐ Change in urinary flow
Genital/Reproductive: **Male--**☐ Pain with sex ☐ Hernia ☐ Penile discharge ☐ Genital sores ☐ Masses or pain ☐ Difficulty sustaining an erection
Female--☐ Pain with sex ☐ Vaginal dryness ☐ Hot flashes ☐ Vaginal discharge ☐ Vaginal itching or rash ☐ Sores
Extremities: ☐ Calf pain with walking ☐ Leg cramping
Musculoskeletal: ☐ Muscle pain ☐ Joint pain ☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints ☐ Recent trauma/injury
Neurologic: ☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness (localized/in one area only) ☐ Numbness ☐ Tingling
Hematologic: ☐ Easy bruising
Endocrine: ☐ Heat or cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst ☐ Eating much more than usual
Psychiatric: ☐ Nervousness/anxiety ☐ Depression ☐ Memory loss ☐ Stress ☐ Poor motivation ☐ Difficulty concentrating

PAST MEDICAL HISTORY

Are you allergic to any medications? ______No _____Yes: which ones (list REACTION after each)?_________________________________
____

Do you have any history of:

☐ Alcoholism
☐ Allergies (to __________)
☐ Anemia
☐ Anxiety
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clot
☐ Breast Lump ☐☐☐☐☐
☐ Bronchitis
☐ Bulimia
☐ Cancer (type____)
☐ Cataract
☐ Chicken Pox
☐ Diabetes
☐ Depression
☐ Drug Use (type ________)
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Failure
☐ Hepatitis (type ____)
☐ Hernia
☐ High Cholesterol
☐ HIV positive
☐ Kidney Disease
☐ Kidney Infection
☐ Kidney Stone
☐ Liver Disease
☐ Migraine headaches
☐ Metabolic Disorder
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Osteoporosis
☐Peptic Ulcer
☐ Pneumonia
☐Prostate problem
☐ Reflux (GERD)
☐Rheumatic Fever
☐Scarlet Fever
☐Sexually transmitted infection (type ____)
☐Stroke
☐Suicide attempt
☐Thyroid problem
☐Tonsillitis
☐Tuberculosis
☐Tropical disease (type________)
☐Urinary tract infection
☐Vaginal infection
☐ Other(________________________

Have you had any surgeries? Please list type and approximate date:

____ ____

Have you ever been hospitalized? ___No ___Yes. If yes, for what reason? ____

Have you ever had a blood transfusion? _____ If yes, approximate date ____

Have you served in the armed forced? ____ If yes, indicate type & years of service _____________________________________

List medications you currently take. Include all prescription, over-the-counter and herbal medications and the dose of each.

____ ____

____ ____

Check the immunizations or screening tests you've had. Please give the approximate (last) date for each.

☐ Measles ________________________ ☐ Colonoscopy ____________________________________
☐ Rubella ________________________ ☐ Mammogram ____________________________________
☐ Chicken Pox ____________________ ☐ Dexascan ____________________________________
☐ Tetanus (Td) ____________________ ☐ Other ____________________________________
☐ Tetanus with pertussis(Tdap) ________
☐ Pneumonia ______________________
☐ Influenza _______________________
☐ Shingles _______________________
☐ Meningococcal __________________

GYNECOLOGICAL & PREGNANCY HISTORY (if applicable)

Age of 1st menstrual period ______________ Number of pregnancies ____________

How often do you have a menstrual period? Every ___ days Number of miscarriages ________

Any problems with your periods? Number of terminations_________

Age at 1st intercourse? Number of live births _________

Type of contraception used? Number of still births _________

FAMILY MEDICAL HISTORY

Father Mother Child Sibling Grandparent Other

Alcoholism ☐☐☐☐☐☐
Alzheimer's/Dementia ☐☐☐☐☐☐
Asthma or Allergies ☐☐☐☐☐☐
Bipolar Disorder ☐☐☐☐☐☐
Bleeding Disorder ☐☐☐☐☐☐
Cancer: type _______________ ☐☐☐☐☐☐
Depression, Anxiety ☐☐☐☐☐☐
Diabetes ☐☐☐☐☐☐
Heart Disease ☐☐☐☐☐☐
High Blood Pressure ☐☐☐☐☐☐
Kidney Disease ☐☐☐☐☐☐
Mental Illness ☐☐☐☐☐☐
Osteoporosis ☐☐☐☐☐☐
Stroke ☐☐☐☐☐☐
TB ☐☐☐☐☐☐
Thyroid Disease ☐☐☐☐☐☐
Other _______________ ☐☐☐☐☐☐

SOCIAL HISTORY

What is your religious/faith background?______________ Do you attend services regularly?_____ Have you ever smoked? ___**If yes**, for how many years? ___ How much do you smoke now? ______**If you no longer smoke**, when did you stop?
Do you drink alcohol? _______ Kind of alcohol? ______ Number of alcoholic drinks/servings you consume per week? ___ Most at one time?____ Have you ever had a problem with alcohol or felt you should cut down? _____
Have you ever used illegal substances? ___No ___Yes. If yes, type ____________ When was the last time you used?___ Have you ever overused prescription medications? ___No ___If yes, type ____________
Sexual Preference: ___Men ___Women ___Both Are you: ___Single ___Married ___Partnered ___Separated ___Divorced ___ Widowed
Do you feel safe in your current relationship? ___ No ___ Yes Do you work outside the home? ___No ___Yes: occupation_____________________
Exercise: Type, duration & frequency ____ Caffeine: # ___ soda ___ tea ___ coffee per day
Any occupational concerns: (stress, hazardous substances, air pollution, heavy lifting)? ________________________
Do you have a Health Care Directive? ____ If no, would you like to have one? ________

Patient Signature (or legal guardian) ____ Date: ___________