CONNER CLINIC
COMPLETE FAMILY HEALTH CARE

Today's Date: _____

Adult Patient History Form

Name _____ **Date of Birth**_____ **Sex**: M ____ F ____
Present Complaints _____
Currents Medical Conditions _____
Preferred Pharmacy (please include address) _____
Current Medications and Dosages (including vitamins/nonprescription drugs/herbs/laxatives etc. You may attach list or write on back): _____

_____

_____

Allergies: (Medication, Foods, Pollen, Etc) _____
Past Medical History: Have you ever had the following:

- ❒ High Blood Pressure
- ❒ Heart Attack/Angina
- ❒ Heart Murmur
- ❒ Crohn's Disease
- ❒ Rheumatic Fever
- ❒ Pneumonia
- ❒ Emphysema
- ❒ Prostate Trouble
- ❒ HIV Disease
- ❒ Asthma
- ❒ Tuberculosis
- ❒ Phlebitis
- ❒ Bleeding Disorder
- ❒ Sickle Cell Anemia
- ❒ Blood Transfusion
- ❒ Gallstones
- ❒ High Cholesterol
- ❒ Hepatitis
- ❒ Kidney Disease/Stone
- ❒ Stomach Ulcers
- ❒ Diabetes
- ❒ Thyroid Disease
- ❒ Cancer
- ❒ Sexually Transmitted Disease
- ❒ Arthritis
- ❒ Stroke
- ❒ Migraine headaches
- ❒ Seizures
- ❒ Anxiety
- ❒ Glaucoma
- ❒ Cataracts
- ❒ Depression
- ❒ Trouble achieving and/or maintaining an erection

Other Serious Illnesses/Hospitalizations/Injuries:

_____

_____

Surgical History: Please list all prior surgeries and dates:

_____

Immunizations (Please list date of last vaccination)

❒ Hepatitis A_____ ❒ Hepatitis B_____ ❒ Pneumovax (pneumonia) _____
❒ Influenza (flu) _____ ❒ Tetanus _____ ❒ Other _____

Health Maintenance Screening Tests: Please list the date and indicate if results were abnormal

Lipid (cholesterol)_____ Abnormal? ❒ Yes ❒ No
PSA(prostate) _____ Abnormal? ❒ Yes ❒ No
Colonoscopy _____ Abnormal? ❒ Yes ❒ No Dexa Scan _____ Abnormal? ❒ Yes ❒ No
Mammogram_____ Abnormal? ❒ Yes ❒ No Pap Smear_____ Abnormal? ❒ Yes ❒ No

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Name _____ **Date of Birth**_____

Family History:

	Age:	Alive:	Deceased:	Health Problems:
Father				
Mother				
Sister				
Brother				
Paternal Grandparents				
Maternal Grandparents				
Children				
Other:				

Habits:

	Yes	No	Amount/Type
Use Drugs (marijuana, cocaine, etc.)			
Use Tobacco: (Cigarettes, Pipe, Cigar, Snuff, Chew)			
Use Alcohol: (Beer, Wine, Liquor)			
Use Caffeine: (Coffee, Tea, Soda)			
Diet: (Restrictions, Special Diet)			
Exercise Regularly			
Wear seat belts?			
Bike Helmet			

Sexual Activity: ❒ Yes ❒ No ❒ Not Currently Current sex partner(s) are: ❒ Male ❒ Female
Birth Control Method: _____ ❒ None Needed
Have you ever had any sexually transmitted diseases (STD's)? ❒ No ❒ Yes
Are you interested in being screened for sexually transmitted diseases? ❒ No ❒ Yes

Other Concerns:
Are you satisfied with your weight? ❒ No ❒ Yes
How do you rate your diet? ❒ Good ❒ Fair ❒ Poor
Do you eat or drink four servings of diary or soy daily or take calcium supplements? ❒ No ❒ Yes
Is violence at home a concern? ❒ No ❒ Yes Have you ever been abused? ❒ No ❒ Yes
Do you have a gun in your home? ❒ No ❒ Yes
Do you have a living will or durable power of attorney for your healthcare? ❒ No ❒ Yes
Do you have a living will or advance directive? ❒ No ❒ Yes
Are you interested in information about this? ❒ No ❒ Yes

Socioeconomics: Occupation: _____ Employer: _____
Years of education/highest degree: _____ Spouse/partner's Name: _____
Number of children/ages: _____ Who lives in the home with you?_____

Women's History: # Pregnancies_____ # Deliveries ____ # Abortions ____ # Miscarriages ___
Regular Periods ❒ No ❒ Yes Age at start of periods: _____ Age at end of periods: _____
Age of Menopause: _____ Do you perform monthly self breast exams: ❒ No ❒ Yes