

Chart Number _____

Date _____

Name of Patient _____

Patient's Occupation _____ Employer _____

Employer's Address _____ Phone _____

Spouse's Name _____ Spouse's Employer _____

Name and Address of Contact Person Not Living In Your Home _____

_____ Phone _____

Hospital or Medical Insurance Co. _____

Insurance Policy # _____ Name of Card Holder _____

Card Holder's SSN _____

Authorization to Release Medical Information _____

Assignment of Insurance Benefits to Physicians _____

Referred by _____

Patient's Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____ SSN _____

Cell Phone _____ Work Phone _____

ADULT PATIENT HISTORY PAGE 2

FOR WOMEN

Age at first period _____ Date of last period _____ Age at menopause _____
 Regular Periods? Yes _____ No _____ Interval between periods _____ Length of periods _____
 # of Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____ Stillbirths _____
 Birth Control Method _____ Doing monthly self breast exam? _____

ALLERGIES (Medication, Foods, Pollens, etc.)

CURRENT MEDICAL OR PSYCHOLOGICAL PROBLEMS

List all conditions currently being treated: _____ Name of Physician: _____

CURRENT MEDICATIONS

(List name, dosage, times per day. Include nonprescription drugs, vitamins, laxatives, herbs, etc.)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

HABITS Do you:

	Yes	No	Amount/ Type
Use drugs (marijuana, cocaine)			
Use tobacco (cigarettes, cigars, chewing tobacco)			
Use alcohol (beer, wine, liquor)			
Use caffeine (coffee, tea, colas)			
Diet (restrictions, special diet)			
Exercise regularly			
Wear seat belts?			

WHEN DID YOU LAST HAVE THESE PERFORMED?

Prostate Exam _____ Breast Exam _____ Rectal Exam _____
 EKG _____ Mammogram _____ Stool Test for Blood _____
 Cholesterol _____ Pap Smear _____ Colon Scope Test _____

Have you ever been: _____ on disability? _____ Denied life or health insurance? _____

Have you had a significant weight change in the last year? _____

Do you have a living will or advance directive? _____ If not, are you interested in information about this? _____

WHAT ARE THE MOST IMPORTANT MEDICAL PROBLEMS YOU HAVE NOW?

*Please
Answer*

ADULT PATIENT HISTORY

Date _____

Name _____ Date of birth _____ Sex M ___ F ___

Occupation _____ Marital Status Single ___ Married ___

Race _____ Age _____ Divorced ___ Widowed ___

PAST MEDICAL HISTORY

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

Have you ever had any of the following (Circle)

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: _____

OPERATIONS

(Give date or age)

Tonsils _____ Gallbladder _____ Kidney _____ Biopsy _____
Appendix _____ Stomach _____ Hysterectomy _____ Prostate _____
Hernia _____ Heart _____ Ovaries Removed _____ Breast _____
Other _____ Tubal Ligation _____

OTHER HOSPITALIZATIONS/ ACCIDENTS/ INJURIES _____

FAMILY HISTORY

	Age	Alive	Deceased	Health Problems
Father				
Mother				
Sister				
Sister				
Brother				
Brother				
Children				

IMMUNIZATIONS (Approximate date or age) PPD _____
Flu _____ Pneumonia _____ Tetanus _____ Hepatitis _____

How did you hear about us???

Please Check
(All that apply)

- Phone Ad
- Newspaper Ad
- Internet
- Friend Referral
- Doctor Referral

(if so then from whom) _____