



# Adult Medical History Form

Please complete All **3** PAGES

Name \_\_\_\_\_

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

**PRESENT HEALTH CONCERNS:** \_\_\_\_\_

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

Medication	Dose	Times per day

Medication	Dose	Times per day

**ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:** (Please include all skin allergies)

Medication	Reaction or Side Effect

Do you take any BLOOD THINNERS (e.g. Aspirin, Advil, Ibuprofen & Motrin)? No Yes

**PERSONAL MEDICAL HISTORY:**

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

\_\_\_ Congenital Heart disease:  
*specify type* \_\_\_\_\_

\_\_\_ Coagulation (bleeding/clotting) disorder

Other problems

\_\_\_ Myocardial Infarction (Heart attack)

\_\_\_ Cancer (Malignancy)  
*specify type* \_\_\_\_\_

\_\_\_\_\_

\_\_\_ Hypertension (High blood pressure)

\_\_\_ Depression/suicide attempt

\_\_\_\_\_

\_\_\_ Diabetes

\_\_\_ Alcoholism

When was your last Tetanus shot?

\_\_\_ High cholesterol \_\_\_\_\_

\_\_\_ If you have ever had a blood transfusion, please specify date

\_\_\_\_\_

\_\_\_ Stroke \_\_\_\_\_

\_\_\_ Abnormal Pap smear

\_\_\_ Thyroid problem

*specify type* \_\_\_\_\_

Have you ever been treated for skin cancer?

No Yes

**SURGICAL HISTORY** (Please list all prior operations and dates):

Operation	Date

Operation	Date

**WOMEN'S GYNECOLOGIC HISTORY:**

Are you pregnant? No \_\_\_\_\_ Yes \_\_\_\_\_  
 For Women: # pregnancies: \_\_\_\_\_ # deliveries: \_\_\_\_\_ # abortions: \_\_\_\_\_ # miscarriages: \_\_\_\_\_  
 1st day, most recent period: \_\_\_\_\_ Age at 1st period: \_\_\_\_\_ Frequency of periods: \_\_\_\_\_ Length of each: \_\_\_\_\_  
 Do you have any concerns about your periods? No Yes: \_\_\_\_\_  
 Do you have any concerns about menopause? No Yes: \_\_\_\_\_

**FAMILY HISTORY:**

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives	Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism								Genetic diseases							
Anemia								Glaucoma							
Anesthesia problem								Hay fever (Allergic Rhinitis)							
Arthritis								Hearing problems							
Asthma								Heart Attack (Coronary Artery Disease)							
Birth Defects								High Blood Pressure (Hypertension)							
Bleeding problem								High cholesterol (Hyperlipidemia)							
Cancer, Breast								Kidney diseases							
Cancer, Colon								Lupus (Systemic Lupus Erythematosus)							
Cancer, Melanoma								Mental retardation							
Cancer, skin (except melanoma)								Migraine headaches							
Cancer, Ovary								Mitral Valve Prolapse							
Cancer, Prostate								Osteoarthritis							
Cancer (not noted)								Osteoporosis							
Depression								Rheumatoid Arthritis							
Diabetes, Type 1 (childhood onset)								Stroke							
Diabetes, Type 2 (adult onset)								Thyroid disorders							
Eczema								Tuberculosis							
Epilepsy(seizures)								Other:							

**SOCIAL HISTORY**

**SUBSTANCES**

**Tobacco Use**

Cigarettes

Quit: Date \_\_\_\_\_

Never

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 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? No Yes

**EXERCISE:**

Do you exercise regularly? No Yes

**SOCIOECONOMICS:**

Occupation: \_\_\_\_\_

Education completed: Grade school High school  
College Graduate school  
Years of education \_\_\_\_\_

Marital status: Single M Sep D W Co-habiting  
Engaged... Other: \_\_\_\_\_

Spouse/Partner's name: \_\_\_\_\_

Number of children: \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

Are you interested in being screened for sexually transmitted diseases? No Yes

Other concerns? \_\_\_\_\_  
\_\_\_\_\_

**SAFETY:**

Do use seatbelts consistently? No Yes  
Do you use a bike helmet regularly? NA No Yes  
Is violence at home a concern for you? No Yes  
Do you feel safe in your current relationship? NA No Yes  
Do you have a gun in your home? No Yes

Other concerns? \_\_\_\_\_  
\_\_\_\_\_

**SEXUALITY**

**Sexual Activity**

Sexually Active: Yes No Not currently  
Current sex partner(s) is/are: male female

**Contraception and Protection**

Birth Control method: \_\_\_\_\_ None needed

If sexually active, do you practice safe sex? NA No Yes

Have you ever had any sexually transmitted diseases (STDs)?  
No Yes

If yes, please include:  
\_\_\_\_\_ date \_\_\_\_\_  
\_\_\_\_\_ date \_\_\_\_\_

**EMOTIONS:**

- 1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? No Yes
- 2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? No Yes
- 3. Have you felt depressed or sad much of the time in the past year? No Yes

**IMMUNIZATIONS:**

Please list your most recent immunizations. You do NOT need to include any immunizations given at Piga Primary Care Associates. Please include your best estimate of the month and year of each immunization:

Hepatitis A \_\_\_\_\_ Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_ Pneumovax (Pneumonia) \_\_\_\_\_  
Hepatitis B \_\_\_\_\_ MMR \_\_\_\_\_  
Tetanus (Td) \_\_\_\_\_ Varicella (chicken pox) shot \_\_\_\_\_ Other \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please check (√) any current problems you have on the list below.

- Constitutional**  
\_\_\_ Fevers/chills/sweats  
\_\_\_ Unexplained weight loss/gain  
\_\_\_ Fatigue/weakness  
\_\_\_ Excessive thirst or urination
- Eyes**  
\_\_\_ Change in vision
- Ears/Nose/Throat/Mouth**  
\_\_\_ Difficult hearing/ringing in ears  
\_\_\_ Problems with teeth/gums  
\_\_\_ Hay fever/allergies
- Cardiovascular**  
\_\_\_ Chest pain/discomfort  
\_\_\_ Leg pain with exercise  
\_\_\_ Palpitations
- Chest (breast)**  
\_\_\_ Breast lump/discharge
- Respiratory**  
\_\_\_ Cough/wheeze  
\_\_\_ Difficulty breathing
- Gastrointestinal**  
\_\_\_ Abdominal pain  
\_\_\_ Blood in bowel movement  
\_\_\_ Nausea/vomiting/diarrhea
- Genitourinary**  
\_\_\_ Nighttime urination  
\_\_\_ Leaking urine  
\_\_\_ Unusual vaginal bleeding  
\_\_\_ Discharge: penis or vagina  
\_\_\_ Sexual function problems
- Musculo-skeletal**  
\_\_\_ Muscle/joint pain
- Skin**  
\_\_\_ Rash or mole change
- Neurological**  
\_\_\_ Headaches  
\_\_\_ Dizziness/light-headedness  
\_\_\_ Numbness  
\_\_\_ Memory loss  
\_\_\_ Loss of coordination
- Psychiatric**  
\_\_\_ Anxiety/stress  
\_\_\_ Problems with sleep  
\_\_\_ Depression
- Blood/Lymphatic**  
\_\_\_ Unexplained lumps  
\_\_\_ Easy bruising/bleeding
- Other (please specify)** \_\_\_\_\_  
\_\_\_\_\_