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Adult Medical History Form ________________________________

Please complete All **4** PAGES Name

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

PERSONAL INFORMATION:

Preferred name (if different from above): ____

What language would you prefer to use with us? __________________________________

Address (if changed since your last visit to our practice, or if you are unsure that we have it):

Street _________________________________ City/town; state; zip code__________________________________

Home phone: ___________________; work phone___________________; cell phone___________________

What is the best way for our office to contact you? *Please circle one or more of above. If you prefer e-mail, please sign up for MyHealth, our secure e-mail site, and circle "MyHealth" on this line.*

Emergency contact: _________________ _____________ ____________ ____________ ____________
Name Relationship home phone work phone cell phone

PRESENT HEALTH CONCERNS: ____

____

____

MY HEALTH CARE GOALS: ____

____

____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs; please continue additional medications on the other side of this page: ☐ I take no regular medications.

Medication	Dose	Times per day

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS: ☐ I am not allergic to any medications.

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:

Do you have any of the following problems?

_____ Acid reflux (heartburn)
_____ Alcoholism / other addiction
_____ Allergies (environmental)
_____ Anxiety
_____ Asthma
_____ Atrial fibrillation
_____ Cancer (specify type ____________________)
_____ Coagulation (bleeding or clotting) problem
_____ Cholesterol problem
_____ Chronic low back pain
_____ Depression

_____ Diabetes mellitus
_____ Erectile dysfunction
_____ Heart disease (specify type_______________)
_____ Hypertension (high blood pressure)
_____ Irritable bowel syndrome
_____ Migraines
_____ Osteopenia or Osteoporosis
_____ Prostate problem
_____ Thyroid problem
_____ Other problems (list below):
_____ ___________________

Have you ever had any of the following problems? If so, please provide approximate year:

Cancer of ___________ ________
please specify

Heart attack? ________
Stroke (CVA) ________

Blood transfusion? ________
Seizure? ________

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

☐ I have had no prior surgery.

Operation	Date

Operation	Date

FAMILY HISTORY:

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

☐ I do not know my family history.

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, other skin							
Cancer, Ovary							
Cancer, Prostate							
Cancer (not noted)							
Colon Polyps							
Depression							
Diabetes, Type 1 (child)							
Diabetes, Type 2 (adult)							
Eczema							
Epilepsy (Seizures)							

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Genetic diseases							
Glaucoma							
Hay fever (Allergies)							
Hearing problems							
Heart Attack (CAD)							
High Blood Pressure							
High cholesterol							
Kidney diseases							
Lupus (SLE)							
Mental retardation							
Migraine headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke (CVA)							
Thyroid disorders							
Tuberculosis							
Other:							

SOCIAL HISTORY

SUBSTANCES:

Tobacco Use

Please check one:

- I have never smoked.
- I have smoked, but rarely.
  When was the last time? ________
- _ I have quit smoking. Quit: Date___________
- _ I currently smoke____pack(s)/day, # of yrs. ____
  Other Tobacco: _ Pipe _ Cigar _ Snuff _ Chew
  Are you interested in quitting? _ No _ Yes

Alcohol Use

Do you drink alcohol? _ Never _ Occasionally _ Regularly
Average# drinks/week: ___5 oz glasses wine;
___12 oz cans beer; ___1.5 oz shots hard liquor
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

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________
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
Are you currently in a relationship? _ No _ Yes
If yes, do you feel safe in this relationship? _ No _ Yes
Do you have a gun in your home? _ No _ Yes
Other concerns?____

EXERCISE:

How active are you?

- _ I get a cardiovascular work-out 3 or more times/week.
- _ I walk daily but do not work out.
- _ I exercise or walk less than 3 times/week.
- _ I am not generally active.
- _ [other] ________________

PREFERRED PHARMACY: ___________________________
Include Address if not HVMA Pharmacy

SOCIOECONOMICS:

Ethnic Background: How would you best describe yourself? (check only one)
_ Asian _ Black, Non-Hispanic _ Hispanic
_ Native American _ Native Hawaiian & Other Pacific Islander
_ White, Non-Hispanic _ Other _ Decline

Marital status: _ Single _ Married _ Sep _ Div _ Widow
_ Co-habiting _ Engaged… _Other: ______________________
Spouse/Partner's name: ________________________________

Number of children: ____
Who lives at home with you? ___________________________

Occupation:________________________

Education completed: _ Grade school _ High school
_ College _ Graduate school

EMOTIONS:

Over the past two weeks, how often have you been bothered by any of the following problems?
Please insert appropriate number for each question, using the following scale:

0 = Not at all
1= Several days
2 = More than half the days
3 = Nearly every day

- Little interest or pleasure in doing things? ____
- Feeling down, depressed or hopeless? ____

IMMUNIZATIONS:
Please list your most recent immunizations. You do NOT need to include any immunizations given at Atrius Health. Please include your best estimate of the month and year of each immunization:

Hepatitis A ____
Hepatitis B ____
HPV ___
Tetanus (Td) ____ TdaP____

Measles ____ Mumps____ Rubella____
MMR____ Meningitis____
Varicella (chicken pox) shot ____

Pneumovax (Pneumonia)____
Shingles____
Other ____________________

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

Breasts

___Breast pain/lump/discharge

Constitutional

___Fevers/chills/sweats

___Unexplained weight loss/gain?

___Fatigue/weakness

Eyes

___Change in vision

Ears/Nose/Throat/Mouth

___Difficult hearing

___Ringing in ears

___Problems with teeth/gums

___Hay fever/allergies

Respiratory

___Cough/wheeze

___Difficulty breathing

Cardiovascular

___Chest pain/discomfort

___Leg pain with exercise

___Palpitations

Gastrointestinal

___Abdominal pain

___Heartburn

___Bloody/black bowel movement

___Nausea/vomiting/diarrhea

___Constipation

___Change in bowel habits

Genitourinary

___Nighttime urination

___Difficulty starting urination

___Leaking urine

___Painful urination

___Blood in urine

___Discharge from penis

___Sexual function problems

Musculoskeletal

___Muscle/joint pain or swelling

Neurological

___Headaches

___Dizziness/light-headedness

___Numbness

___Memory loss

___Loss of coordination

Psychiatric

___Anxiety/stress

___Problems with sleep

___Depression

Skin

___Rash or mole change

___Itching

Blood/Lymphatic

___Unexplained lumps

___Easy bruising/bleeding

Endocrine

___Excessive thirst or urination

Other (please specify) ______________________________

____

____

☐ I have none of the above problems.