Huntington Family Medicine

Adult History Form

Name: ______________________ DOB: ____________ Age_______

Main reason for initial visit: ____

PHARMACY
LOCATION____

MEDICATIONS

_______________________________ _____________________________
_______________________________ _____________________________
_______________________________ _____________________________
_______________________________ _____________________________
_______________________________ _____________________________

ALLERGY TO ANY MEDICATION: __________________________________

PRIOR OR CURRENT MEDICATION PROBLEM:

__Heart Disease __High Blood Pressure __High Cholesterol
__Diabetes __Thyroid Disease __Asthma/COPD/ Lung Disease
__Anemia __Kidney Disease __Migraines
__Arrhythmia __Stroke (Date)________ __Heart Attack (Date) ________
__Cancer (what type): _____________________ Date: ___________________
_____________________ ___________________
__Depression
Any others: ___________________ _____________________
____________________ _____________________

PRIOR SURGERIES: Please indicate what surgeries you've had and the dates:
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

(Women Only): Please indicate the number of pregnancies and deliveries below:

Pregnancies__________________ Live births_____________
C-sections___________________ Vaginal deliveries______
Miscarriage__________________ Abortions______________
Menopause_________ Age___________

PRIOR HOSPITALIZATIONS: Please indicate any other hospitalizations with dates:
__________________________________ ___________________________________
__________________________________ ___________________________________
__________________________________ ___________________________________

FAMILY HISTORY: Please indicate any medical illnesses in your family including (but not limited to) history of heart attacks, heart disease, diabetes, high blood pressure, cancers and strokes:

Family Member	Disease	Age of Onset
______________________	___________________	_______________
______________________	___________________	_______________
______________________	___________________	_______________

SOCIAL HISTORY

Occupation: _________________________

Marital Status: _______________________ # of children: ____________

Tobacco:

__ Never smoked regularly

__ I used to smoke ______ packs/day for ______ years, but I quit in ___________.

__ I currently smoke _______packs/day for _______years.

***Please let us know if you are interested in quitting!**

Alcohol: Do you currently drink alcohol? __________ What type? ____________

I drink __________ (number of drinks) every ____________ (day,week,month)

Is your alcohol a concern for you or others? ______________

Caffeine: Do you drink caffeine? _________ What type(s)? ____________________

How many cups/day? ____________

Drugs: Do you use recreational drugs? ____________ What type(s)? _______________

Have you ever used injected drugs? __________________

Activity level: Do you exercise regularly? _________ What type(s)? ________________

How many times / week? ____________________

Sexual Activity: have you ever been sexually active? ________ Currently active? ______

Have you ever had a sexually transmitted disease (STD)? ____________________

Are you interested in being screened for STDs? _____________

HEALTH MAINTENANCE

Date of Immunizations: Flu Shot_________ Tetanus ___________

Pneumonia_______ Shingles___________

Date of:

Last Physical _________________

Colonoscopy _________________

For **Men**: PSA ________________

For **Women**: Mammogram ______________ Pap Smear _______________

Bone Density (DEXA): _______________________

Have you filled out an Advance Directive or a Living Will? ______________________

Are you interested in information on these issues? ______________________