ADULT MEDICAL HISTORY

DATE: / /

PATIENT NAME:	BIRTHDATE / /	AGE	SEX M F

PERSONAL ILLNESS OR MEDICAL PROBLEMS

Please mark with an "X" any of the following illnesses and medical problems you have, or have had and indicate the year when each started. If you are not certain when an illness started, write down the approximate year.

ILLNESS	"X"	YEAR	ILLNESS	"X"	YEAR	ILLNESS	"X"	YEAR
Eye or Eye Lid Infection			Arteriosclerosis			Epilepsy		
Glaucoma			Heart Murmur			Head Injury		
Cataract			Other Heart Condition			Stroke		
Other Eye Problems			Stomach/Duodenal Ulcer			Seizures		
Deafness			Diverticulosis			Arthritis		
Ringing Sound in Ears			Colitis			Cancer/Tumor		
Bronchitis			Gout			Bleeding Tendency		
Emphysema			Yellow Jaundice			Diabetes		
Pneumonia			Liver Trouble			Hepatitis		
Allergies			Gall Bladder Trouble			Measles		
Asthma			Hernia			Mononucleosis		
Tuberculosis			Hemorrhoids			Psoriasis		
Other Lung Problems			Kidney or Bladder Disease			Other Skin Problems		
High Blood Pressure			Prostate Problem(s)			Mental Illness		
Heart Attack			Migraine Headaches			Alcoholism		
High Cholesterol			COPD			Other: _____		

FAMILY HEALTH HISTORY

Relationship	Age If Living	Age At Death	State of Health or Cause of Death	Please indicate any BLOOD relatives that have had any of the following: ILLNESS — FAMILY MEMBER
Father				Diabetes
Mother				Cancer: Type?
Brother(s)				Blood Disease
				Glaucoma
				Seizures/Epilepsy
Sister(s)				Arthritis
				Tuberculosis
				High Blood Pressure
Spouse				Heart Disease
Children				Kidney Disease
				Alcoholism
				Mental Illness: Type?
				Gout
				Gall Stones/Other:

HOSPITALIZATIONS AND SURGERIES — CHECK BOX IF NONE

Please list the last four times, if any, that you have been hospitalized. Do not include normal pregnancies.

YEAR	OPERATION OR ILLNESS	HOSPITAL & CITY

CURRENT MEDICATIONS — Check Box if None	ALLERGIES to Medications — Check Box if None
Please list all Medications you are now taking. Include those you buy without a prescription (such as aspirin or cold tablets). MEDICATION NAME — DOSAGE — FREQUENCY	Please list any allergies to Medications you have had. Please DO NOT INCLUDE food allergies or hay fever.

SOCIAL HISTORY	
Your Occupation:	**Marital Status:** **Single Married Divorced Widowed Separate**
Have you ever been exposed to chemicals or other harmful substances at work or elsewhere?	**You currently live :** **Alone with Friends with Parents with Family** **Last grade completed in school:** **6 7 8 9 10 11 12 College: 1 2 3 4 Graduate School**
Are you sexually active? YES NO	**What is your sexual preference? Male Female**
Do you feel your life is stressful? YES NO	**Date of last Tetanus Vaccination:**
Did you have radiation treatment as a child? YES NO	
Please describe your eating habits:	
Please describe your exercise habits, type and frequency:	
Are there any medical or psychological problems that run in your family? YES NO If YES, please explain.	
SMOKING:	
Do you currently Smoke? YES NO Are you a former Smoker/Tobacco user? YES NO When did you quit?	
If YES to either question, circle the tobacco you use(d): Cigarettes Cigar Pipe Chewing Tobacco	
How much per day? How many years?	
DRINKING:	
Do you currently Drink? YES NO	
If YES, What kind(s) of alcohol do you drink?	
How much do you drink on one occasion?	
How often do you drink? daily a few times a week one a week once a month other?	
DRUG USE:	
Do you (or have you in the past) used: Marijuana YES NO	
Cocaine YES NO	
Previous I.V. Drugs YES NO	
Other Drugs, Specify: YES NO	
Do you drink coffee, tea or colas? YES NO If YES, how much per day?	

FEMALE ONLY		MALE ONLY
Age menstrual period began:	**Vaginal itching/burning**	**Hernia**
Date last period began:	**Vaginal discharge**	**Discharge from penis**
Could you possibly be pregnant? YES NO	**Problem with periods**	**Pain in testicles**
Age at menopause:	**Sexual difficulties**	**Venereal disease**
Pregnancies:	**Lumps in breast(s)**	**Sexual difficulties**
____# LIVE BIRTHS ____# MISCARRIAGES	**Venereal disease**	**Vasectomy**
____# CESAREAN ____# PREMATURE	**Discharge from nipple(s)**	**Other problems(s)**
____# STILLBORN ____# ABORTIONS	**Tubal ligation**	**Please describe:**
How many living children:	**Pelvic Inflammatory Disease (PID)**	
Method(s) of contraception used:	**Other problem(s) Please describe:**	
Date of last mammogram:		
Date of last pap smear:		
Please add any other comments not covered above:		