FirstChoice Family Medicine

Adult Medical History Form

Please complete all 5 pages

_____
Name

Your answers on this form will help your clinicians understand your medical concerns and conditions better. If you are uncomfortable with any question, do 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:

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:
Do you have now (current) or have you had (past) any of the following conditions? ❑**NONE**

Condition	***Code***	***Current***	***Past***	***Comments***
Alcohol / Drug abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.9			
Bladder / Kidney Problems				
Blood Clot (leg)	453.40			
Blood Clot (lung)	415.11			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Gallbladder Disease	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			

PERSONAL MEDICAL HISTORY Continued: ***Condition***	***Code***	***Current***	***Past***	***Comments***
Glaucoma	365.9			
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Heart Attack	410.90			
Hepatitis – Type A	070.1			
Hepatitis – Type B	070.30			
Hepatitis – Type C	070.51			
Hepatitis – Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.9			
Stroke	434.91			
Thyroid High (Overactive) / Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (list)				
Other (list)				

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

Operation	Date

Operation	Date

WOMEN'S GYNECOLOGIC HISTORY:

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
Alcoholism							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, Ovary							
Cancer, Prostate							
Cancer (not noted)							
Depression							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							

Medical Condition	Mom	Dad	Sist	Bro	Daug	Son	Other close relatives
Epilepsy (seizures)							
Genetic diseases							
Glaucoma							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure (Hypertension)							
High cholesterol (Hyperlipidemia)							
Kidney diseases							
Lupus (Systemic Lupus Erythematosis)							
Mental retardation							
Migraine headaches							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
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? _____

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 _____

Are you interested in being screened for STDs?
□No □Yes

Other concerns?
_____
_____

SAFETY

Do you 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?
_____
_____

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. Please include your best estimate of the month and year of each immunization:

Hepatitis A_____
Hepatitis B_____
Tetanus (Td)_____
Measles_____Mumps_____Rubella_____
MMR_____
Varicella (chicken pox) shot_____
Pneumovax (Pneumonia)_____
Other_____

HEALTH MAINTENANCE SCREENING TESTS

Lipid (cholesterol)	Date _____	Abnormal?	□No	□Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date _____	Polyp?	□No	□Yes
Women only:				
Mammogram	Date _____	Abnormal?	□No	□Yes
Pap Smear	Date _____	Abnormal?	□No	□Yes
Bone Density Test	Date _____	Abnormal?	□No	□Yes

REVIEW OF SYSTEMS:
Please check (√) any <u>current</u> 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 specific) _____
_____