

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:

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Congenital Heart disease:
<i>specify type</i> _____ | <input type="checkbox"/> Coagulation (bleeding/clotting) disorder | Other problems
_____ |
| <input type="checkbox"/> Myocardial Infarction (Heart attack) | <input type="checkbox"/> Cancer (Malignancy)
<i>specify type</i> _____ | _____ |
| <input type="checkbox"/> Hypertension (High blood pressure) | <input type="checkbox"/> Depression/suicide attempt | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | When was your last Tetanus shot?
_____ |
| <input type="checkbox"/> High cholesterol _____ | <input type="checkbox"/> If you have ever had a blood transfusion, please specify date | |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Abnormal Pap smear | |
| <input type="checkbox"/> Thyroid problem
<i>specify type</i> _____ | | |

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	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 Harvard Vanguard Medical 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) _____