Harvard Vanguard Medical Associates
Atrius Health

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
____ Heart disease (specify type_____)
____ Hypertension (high blood pressure)
____ Irritable bowel syndrome
____ Migraines
____ Osteopenia or Osteoporosis
____ Polycystic ovaries
____ 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							

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:							

Epilepsy (Seizures)																

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

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] _____

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

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

***E* ars/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
___Leaking urine
___Painful urination
___Blood in urine
___Unusual vaginal bleeding
___Vaginal discharge
___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.

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: _____
If you have stopped having periods, please specify when you reached menopause: _____
Do you have any concerns about menopause? □ No □ Yes: _____
Have you ever had an abnormal Pap test? □ No □ Yes; if yes, specify when _____.
Were you exposed to DES (estrogen treatment) while your mother was pregnant with you? □ No □ Yes