PORTER STARKE SERVICES
Health • Balance • Hope

Medical History – ADULT (age 18 and up)

Directions: You can complete this form now and bring it with you to Porter-Starke Services. **Option A**: Type in your answers on the computer and then print it. **Option B:** Print the form first and then write in your answers. Please print clearly.

Client Name: _____ Date Completed: _____

Date of Birth: _____ Current Age: _____ Occupation: _____

Education Completed: ☐ Primary (K-8) ☐ Secondary (High School) ☐ Vocational ☐ Undergraduate ☐ Post-graduate

Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Referred by: _____ Therapist: _____ Primary Care MD: _____

What brings you here today?

When did the issues/problems begin?

Your Family History

Father	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____
Mother	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____
Sibling 1	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____
Sibling 2	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____
Sibling 3	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____
Spouse	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____
Child 1	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____
Child 2	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____
Child 3	Age: ____	Significant health issue(s): _____	If deceased, age at death: _____	Cause: _____

Has a blood relative ever had one of the following conditions?

Cancer	☐ No ☐ Yes	If yes, specify relative: _____
Tuberculosis	☐ No ☐ Yes	If yes, specify relative: _____
Diabetes	☐ No ☐ Yes	If yes, specify relative: _____
Heart Trouble	☐ No ☐ Yes	If yes, specify relative: _____
High Blood Pressure	☐ No ☐ Yes	If yes, specify relative: _____
Stroke	☐ No ☐ Yes	If yes, specify relative: _____
Epilepsy	☐ No ☐ Yes	If yes, specify relative: _____
Mental Illness	☐ No ☐ Yes	If yes, specify relative: _____
Suicide	☐ No ☐ Yes	If yes, specify relative: _____
Alcoholism	☐ No ☐ Yes	If yes, specify relative: _____

Staff use only below this line *Staff use only below this line* *Staff use only below this line*

PORTER-STARKE SERVICES, INC

CLIENT NAME: _____ CLIENT NUMBER: _____

NURSE INITIAL/DATE: _____ /_____ DOCTOR INITIAL/DATE: _____ /_____

Your Personal History

Date of last physical exam: _____

Medications

Please list all medications you are currently taking:

1. _____
2. _____
3. _____
4. _____

Current Health Symptoms

For each category, please check all that apply.

Constitutional

- ☐ Fever
- ☐ Weight loss
- ☐ Generalized weakness
- ☐ Fatigue
- ☐ Night sweats
- ☐ Other (specify) _____

Allergic/Immunologic

- ☐ History of allergies
- ☐ Eczema
- ☐ Hives or itching
- ☐ Frequent sneezing

Allergies

- ☐ Penicillin or sulfa
- ☐ Aspirin, codeine or morphine
- ☐ Mycins or other antibiotics
- ☐ Other drug:_____ _____
- ☐ Food: _____

Eyes

Date of last eye exam: _____

- ☐ Glaucoma or cataracts
- ☐ Eye infections or injury
- ☐ Blurred or double vision
- ☐ Light sensitivity
- ☐ Visual disturbances
- ☐ Spots or flashing lights
- ☐ History of retinal detachment

Ear, Nose, Throat or Mouth

Date of last dental exam: _____

Date of last hearing test: _____

- ☐ Sensitivity to noise
- ☐ Ear pain
- ☐ Ringing in the ear
- ☐ History of ear infections
- ☐ Vertigo (dizziness)
- ☐ History of nose bleeds
- ☐ Impaired ability to smell
- ☐ Pain over sinuses
- ☐ History of sinus infections
- ☐ Use of dentures
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Impaired ability to taste

Cardiovascular

- ☐ History of chest pain
- ☐ Heart palpitations
- ☐ Heart murmurs
- ☐ Irregular pulse
- ☐ Hypertension
- ☐ Problems breathing
- ☐ Coldness or numbness in hands or feet
- ☐ Swelling
- ☐ Leg pain or pain in arm

Respiratory

- ☐ History of asthma
- ☐ Hay fever
- ☐ Chronic cough
- ☐ Coughing up of blood
- ☐ Wheezy or noisy breathing
- ☐ History of bronchitis or pneumonia
- ☐ Shortness of breath

Gastrointestinal

- ☐ Indigestion or paid when eating
- ☐ Vomiting of blood
- ☐ Frequent nausea or vomiting
- ☐ History of liver disease or jaundice
- ☐ History of gallbladder disease
- ☐ Changes in bowel habits
- ☐ History of diarrhea or constipation
- ☐ History of hemorrhoids
- ☐ Use of digestive aids or laxatives

Staff use only below this line *Staff use only below this line* *Staff use only below this line*

PORTER-STARKE SERVICES, INC

CLIENT NAME: _____ CLIENT NUMBER: _____

NURSE INITIAL/DATE: _____ /_____ DOCTOR INITIAL/DATE: _____ /_____

Your Personal History *(continued)*

Genitourinary

- ☐ Painful urination
- ☐ Changes in patterns of urination
- ☐ Hesitancy in starting stream or urine
- ☐ Incontinence
- ☐ Frequent urination at night
- ☐ History of renal calculi or flank pain

Musculoskeletal

- ☐ History of fractures
- ☐ Muscle cramping, twitching or pain
- ☐ Joint swelling redness or pain
- ☐ Limitations on walking, running, sports
- ☐ Joint deformity
- ☐ Joint stiffness
- ☐ Noise with joint movement
- ☐ Spinal deformity
- ☐ Chronic back pain

Skin (Integumentary)

Date of last breast exam: _____

- ☐ Known skin disease: _____
- ☐ History of itching
- ☐ Skin reactions to hot or cold
- ☐ Presence of moles, scars, sores
- ☐ Breast pain, tenderness or swelling
- ☐ History of nipple discharge

Neurological

- ☐ History of fainting
- ☐ History of seizures/anticonvulsant therapy
- ☐ History of memory loss
- ☐ Hallucinations
- ☐ Disorientation
- ☐ History of problems with gait, balance or coordination
- ☐ Tremor or paralysis

Psychiatric

- ☐ History of psychiatric illness
- ☐ History of psychiatric hospitalizations
- ☐ History of alcoholism

Hematologic/Lymphatic

- ☐ History of anemia
- ☐ Bleeding tendencies
- ☐ Easy bruising or fatigue
- ☐ History of blood transfusion

For Nurse Use Only

Active Problem List:

1. _____
2. _____
3. _____
4. _____
5. _____

Chronic Problem List:

1. _____
2. _____
3. _____
4. _____
5. _____

Staff use only below this line *Staff use only below this line* *Staff use only below this line*

PORTER-STARKE SERVICES, INC

CLIENT NAME: _____ CLIENT NUMBER: _____

NURSE INITIAL/DATE: _____ /_____ DOCTOR INITIAL/DATE: _____ /_____