Medical History Form - Adult

Name: ________________________________ Account Number: ___________________ Date: ___________

Date of Birth _____/______/______ Age ________ Marital Status (circle): Single Married Divorced Widow

Occupation_________________________________ Education ____

Family History				
	If living		*If deceased*	
	Age	Health	Age at death	Cause
Father				
Mother				
Sibling				
Sibling				
Sibling				
Child				
Child				
Spouse				

Has a blood relative ever had? Check:			
	Yes	No	What relation
Cancer			
Tuberculosis			
Diabetes			
Heart Trouble			
High Blood Pressure			
Stroke			
Epilepsy			
Mental Illness			
Suicide			
Alcoholism			

Please list current medications:			
Name of Medication	Dosage	Name of Medication	Dosage

Current Health Symptoms. Circle any symptoms that are current at this time:	
Constitutional	Fever Weight loss Generalized weakness Fatigue Night sweats Sleep changes Change in appetite Other:
Eyes	Last Exam Date: _____________ Glaucoma Cataracts Infections Injury Blurred Vision Double vision Light sensitivity Visual disturbances Spots/Floaters Flashing Lights Retinal Detachment Eye pain
Nose, Throat, Mouth	Last Hear Test Date:___________ Sensitive to noise Ear pain Ringing Infections Vertigo (dizziness) Nose Bleeds Impaired ability to smell Sinus Pain Sinus Infection Date of Dental Exam Date:__________ Tooth pain Dentures Bleeding gums Difficulty in swallowing Inability to taste Sore throat
Cardiovascular	Chest pain Heart palpitation Heart murmurs Irregular pulse Hypertension Low Blood Pressure Shortness of Breath Coldness/Numbness in hands or feet Swelling Pain in legs or arms Feeling faint or fainting
Respiratory	Asthma Hay fever Chronic cough Coughing up blood Wheezy or noisy breathing History of bronchitis or pneumonia Breathing problems
Gastrointestinal	Indigestion or pain when eating Vomiting of blood Frequent Nausea/Vomiting Jaundice Liver Disease Gallstones/Gallbladder Changes in bowel habits Diarrhea Constipation Hemorrhoids Use of digestive aids or laxatives Unintentional Weight loss/gain

Client Name: ____

Current Health Symptoms. Circle any symptoms that are current at this time: (continued)	
Genitourinary	Painful urination Change in urination pattern Hesitancy in starting stream or urine Incontinence Frequent urination at night History of kidney stones Flank pain Date of last menstrual period____________________ Excessive pain with menstrual periods
Musculoskeletal	History of fractures Muscle cramps Muscle twitch Muscle pain Joint swelling Joint redness Joint pain Limitations on walking, running or sports Joint deformity Joint stiffness Back Pain Noise with joint movement Spinal Deformity
Integumentary (skin)/ Breast	Known skin disease____ History of itching Rash Moles Scars Sores Skin reaction to hot or cold Date of last breast exam__________ Breast pain, tenderness or swelling Nipple discharge
Neurological	Headaches Fainting Seizure Anticonvulsant therapy Weakness Numbness Memory loss Hallucinations Disorientation History with problems with gait, balance or coordination Tremors Paralysis
Endocrine	Diabetes Insulin Thyroid disease Hyperthyroid Hypothyroid Graves Hashimoto's
Psychiatric	History of psychiatric illness History of psychiatric hospitalizations History of alcoholism
Hematologic/Lymphatic	Anemia Bleeding tendencies Easy bruising Easy fatigue History of blood transfusion
Allergic/Immunologic	History of allergies Eczema Hives Itching Frequent sneezing Swollen lymph glands

Allergies			
	yes	no	Type of reaction
Penicillin			
Sulfa			
Aspirin			
Codeine			
Morphine			
Mycins			
Other Antibiotics			
Other Drug			
Food			

DO NOT WRITE BELOW THIS LINE – FOR NURSING STAFF ONLY

Comments:

Nurse Initials _____________ Date _______________ / Physician Initials _______________ Date __________