ADULT PATIENT HISTORY

Todays Date ____________

NAME ________________________ **Male** _____ **Female** _____ **Date of Birth** ____________

Marital Status: Married_____ Separated_____ Divorced_____ Widowed_____ Single_____

Education: Years completed 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19+

Occupation: ________________________

FAMILY HISTORY: For each member of your family, follow the grey or white lines across the page and check the boxes for:
1. Their present state of health 2. Any illnesses they have had

(Note except for *spouse*, Family refers to *blood* or *natural* relatives.)

PRINT NAMES BELOW	Good Health	Poor Health	Deceased	Write in age and cause of death. Include fatal accidents and suicides.	Allergies or asthma	Anemia	Blood clotting problems	Diabetes	Cancer or tumor	Epilepsy	Glaucoma	Genetic disease	Alcoholism	Kidney or bladder trouble	Stomach/duodenal ulcer	Nervous breakdown	Rheumatism or arthritis	High blood pressure	Heart trouble	Gout
Father																				
Mother																				
Brothers/Sisters:																				
Spouse:																				
Child:																				
Child:																				
Child																				
Child:																				
Paternal relatives (in each box, write how many affected with) →																				
Maternal relatives (in each box, write how many affected with) →																				

Patient Medical History: **Please put a check mark if you have had any of the following:** (Leave blank if uncertain.)

Abnormal Pap Smear	___	Cancer	___	HIV + or AIDS	___	Psychological Disorder	___
Allergies / Hay Fever	___	Chicken Pox	___	Hives or Eczema	___	Rheumatic Fever	___
Anemia / Blood Disorder	___	Diabetes	___	Infectious Mono	___	Stroke	___
Arthritis or Gout	___	Epilepsy	___	Kidney Disease	___	Surgery	___
Asthma	___	Glaucoma	___	Migraine Headaches	___	Thyroid Disease	___
Back trouble	___	Heart Disease	___	Mitral Valve Prolapse	___	Tuberculosis	___
Bladder Infections	___	Hemmorrhoids	___	Osteoporosis	___	Ulcer	___
Blood/Plasma Transfusion	___	Hepatitis	___	Pneumonia	___	Venereal Disease	___
Bronchitis	___	High/Low Blood Pressure	___	Prostate Disease	___		

Any Other Disease (please list):________________________

I have reviewed this list and have NONE of the above. ________

Social History:

Alcohol Use: ___No ___Yes How much per week?__________

Illegal Drug Use: ___No ___Yes Type and Frequency:____________

Smoking: ___Never ___Yes ____ Quit (what year?)

Age started? ______ Packs per day______

Caffeine: ___No ___Yes How Much/Day?__________

Exercise: ___No ___Yes How Much/Week? ________

Do you use supplements / herbal medicines? ____Yes ____No If yes, what types? ____________________

Do you have a living will or other advance directives? _____Yes _____No

Do we have a copy? _____Yes _____No

Do you want information on these advance directives? _____Yes _____No Pamphlet given ______________

Initials/date

Form Completed By: ________________________

(Signature)