WESTERN WAYNE PHYSICIANS

Adult Personal History Form

Name_____ Date_____ Reviewed_____

Birth Date _____ Age_____

Please list all allergies to food and medicine _____

_____

Please indicate if you now have or have had the following medical conditions:

	No	Yes		No	Yes		No	Yes
Tuberculosis	____	____	High Blood Pressure	____	____	Diabetes	____	____
Chest Pain	____	____	Asthma	____	____	Hemorrhoids	____	____
Chronic Cough	____	____	Alcoholism	____	____	Glaucoma	____	____
Elev. Cholesterol	____	____	Headaches	____	____	Heart Attack	____	____
Edema	____	____	HIV/AIDS	____	____	Obesity	____	____
Bleeding Disorders	____	____	Cancer	____	____	Venereal Disease	____	____
Seizures	____	____	Constipation	____	____	Kidney Stones	____	____
Rheumatic Fever	____	____	Arthritis	____	____	Thyroid Disorders	____	____
Injuries	____	____	Emotional (Nerves)	____	____	Hepatitis Jaundice	____	____

Other_____

_____

List all medications (prescription and over the counter) you are currently taking: (dosage & frequency)

_____

_____

_____

_____

My last Tetanus shot was_____ Flu Shot_____ Pneumonia_____ Other_____

I exercise (type and frequency)_____

I wear seat belts while driving or riding ___Always ___Usually ___Often ___Occasionally ___Never

I drink caffeinated beverages: coffee, tea, soda ___Always ___Usually ___Often ___Occasionally __Never

Do you smoke? No_____ Yes_____

If yes, list the number of packs per day _____

List the number of years you have smoked _____

List previous hospitalizations for medical problems, state reason for hospitalization and dates:

_____

_____

_____

List previous surgeries and dates: _____

_____

Date of last colorectal cancer screening, i.e. colonoscopy, sigmoidoscopy_____

Where was it done _____

Men: Last testicular exam_____ Last prostate exam_____

Women: Age at last period_____ Date of last period_____
Family History of Breast Cancer _____Yes _____No
List any problems associated with periods of pregnancies_____
_____
List number of pregnancies _____ Miscarriages_____ Abortions_____
Type of birth control used_____
Last pap was on (date)_____ Where done_____
Last mammogram was on (date)_____ Where done_____

Do you drink any type of alcoholic beverages Yes_____ No_____
If yes, indicate the number and type (cans, glasses, bottles) of drinks per week_____
Do you use any type of street drugs, i.e. marijuana, cocaine, etc. No_____ Yes_____
If yes, please list:_____

FAMILY HISTORY

Please indicate with a check any of the following medical problems within your family history:
M = Mother F = Father S/B = Sister/Brother GP = Grandparent A/U = Aunt/Uncle

	M	F	S/B	GP	A/U
High blood pressure					
Allergy/Asthma					
Heart Attack					
Diabetes					
Elevated Cholesterol					
Cancer					
Arthritis					
Kidney Stones					

	M	F	S/B	GP	A/U
Bleeding disorders					
Stroke					
Obesity					
Alcoholism					
HIV/AIDS					
Glaucoma					
Seizures					
Thyroid disorders					

Patient Signature_____ Date_____