

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): _____

Address (if changed since your last visit to HVMA, or if you are unsure that we have it):

Street _____

City/town; state; zip code _____

Home phone: _____; work phone _____; cell phone _____

Emergency contact: _____
Name Relationship home phone work phone cell phone

PRESENT HEALTH CONCERNS: _____

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? _____ Blood transfusion? _____
 Stroke (CVA) _____ 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							
Epilepsy (Seizures)							

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:							

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

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

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] _____

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:

- In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed?
 No Yes
- Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?
 No Yes
- Have you felt depressed or sad much of the time in the past year?
 No Yes

IMMUNIZATIONS:

Please list your most recent immunizations. You do NOT need to include any immunizations given at Harvard Vanguard Medical Associates. Please include your best estimate of the month and year of each immunization:

Hepatitis A ____ Measles ____ Mumps ____ Rubella ____ Pneumovax (Pneumonia) ____
Hepatitis B ____ MMR ____ Meningitis ____ Shingles ____
HPV ____ Varicella (chicken pox) shot ____ Other ____
Tetanus (Td) ____ TdaP ____

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

Ears/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