Adult Medical History Form

New Patients ONLY (including those last seen three or more years ago)

You may skip any questions you have already answered on the portal.

Last Name, First Name, MI	Date of Birth	Place of Birth	Today's Date
	/ /		/ /
Preferred Language	**Race**	**Religious Preference**	**Organ Donor?**

Medical History – List serious illnesses, injuries, operations, and other hospitalizations

Problems/Conditions	YEAR	Surgeries	YEAR

List all your current medications – Include vitamins, herbs, birth control & over-the-counter pills

Medicine Name/Dose (If known)	Medicine Name/Dose (If known)

Have you had an allergic reaction to any medications, foods, or insect bites? **Yes No**
Which medication, food, or insect? _____
_____
Describe reactions _____
_____

Have you ever been hospitalized, other than surgeries listed above? **Yes No**
If yes, when and why?
_____
_____
_____

Have you been treated for mental health issues?
Yes No
If yes, when and why? _____
_____

Have you been under a physician's care for chronic conditions, other than reasons listed above?
Yes No
If yes, describe _____
_____

Do you have a physical disability? **Yes No**
If yes, describe _____
_____

Have you ever been exposed to hazard at your job? **Yes No**
If yes, describe _____
_____

Family History – List all family history such as heart disease, hypertension, alcoholism, mental illness, cancer, diabetes, etc. and age of onset diagnoses if known

Father		Family History Unknown	If yes, explain:
Mother		Sibling(s)	
Paternal Grandfather		Maternal Grandfather	
Paternal Grandmother		Maternal Grandmother	
Paternal Aunt/Uncle		Maternal Aunt/Uncle	