PROVIDENCE
Medical Group

ADULT HISTORY FORM

Name: _____ Today's Date: _____
Date of Birth: _____ Age: _____ Sex: M / F
Place of Birth: _____ Occupation: _____
Marital Status: Single Married Widowed Divorced _____
Spouse: _____ Spouse's Occupation: _____
Chief Complaint (Reason for Visit Today): _____

MEDICAL HISTORY

	YES	NO		YES	NO		YES	NO
Environmental Allergies			Depression			Heart Attack/Coronary Artery Disease		
Anemia			Diabetes			Nerve/Muscle Disease		
Anxiety			Emphysema			Osteoporosis		
Arthritis			Gastro Esophageal Reflux Disease			Seizures		
Asthma			Glaucoma			Sexually Transmitted Diseases		
Blood Transfusion			Heart Murmur			Sickle Cell Anemia		
Cancer			HIV/AIDS			Stroke		
Cataracts			High Cholesterol			Substance Abuse		
Congestive Heart Failure			High Blood Pressure			Thyroid Disease		
Clotting Disorder			Kidney Disease			Tuberculosis		
COPD			Meningitis			Ulcers		
Any additional past Medical History not listed:								

SURGICAL HISTORY

	YES	NO		YES	NO		YES	NO
Appendectomy			C-Section			Joint Replacement		
Brain Surgery			D & C			Prostate Surgery		
Breast Surgery			Ear Surgery			Small Intestine Surgery		
Coronary Artery Bypass Surgery			EGD (Upper Endoscopy)			Spine Surgery		
Cholecystectomy			Eye Surgery			Tonsillectomy		
Colonoscopy			Fracture Surgery			Tubal Ligation		
Colon Surgery			Hernia Repair			Valve Replacement		
Cosmetic Surgery			Hysterectomy			Vasectomy		
Any additional Surgeries not listed:								

FAMILY HISTORY

Please fill in your family history with a check mark for any that apply.

Relationship	Alive/Deceased	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Early Death	Hearing Loss	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Learning Disability	Mental Illness	Mental Retardation	Miscarriages	Stroke	Substance Abuse	Vision Loss	Other
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
MGM																						
MGF																						
PGM																						
PGF																						
Other																						

MGM=Maternal Grandmother PGM=Paternal Grandmother
MGF=Maternal Grandfather PGF=Paternal Grandfather

SOCIAL HISTORY

Alcohol use: YES / NO

If Yes, Drinks per Week: _____ Glasses of wine, _____ Cans/Glasses of beer

_____ Shots of liquor, _____ Drinks containing 0.5 oz. of alcohol

TESTING AND IMMUNIZATIONS

Test	Date Last Done	Results (Circle)
PAP/Pelvic Exam		Normal / Abnormal
Mammogram		Normal / Abnormal
Sigmoidoscopy Colonoscopy		Normal / Abnormal
Prostate Screening (PSA)		Normal / Abnormal
DEXA scan		Normal / Abnormal

Immunization	Year
Tetanus Shot	
Pneumonia Shot	
MMR (measles, mumps, rubella)	
Hepatitis B Series	
Hepatitis A Series	
Polio	
Flu Shot	

TOBACCO USE

Smoking Hx: Current smoke / Never / Former smoker

Packs/day _____ Years smoked _____ Ready to Quit? YES / NO Date Quit _____

ALLERGIES TO MEDICATIONS

Medication	Reaction

MEDICATIONS

Medication Name	Dosage	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Medication Name	Dosage	How Often
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		

Any additional medications:

_____

_____

_____

_____

GYNECOLOGY HISTORY IF APPLICABLE

Are you pregnant?	How many pregnancies	Children Living	Miscarriages	Tubal pregnancy	Preterm	Twins	Abortions

Please indicate if you have had any experience in the last 30 days of the following symptoms:

Yes	No	Symptom	Type
		Unusual Sweating	**Constitution**
		Fatigue	
		Fever	
		Hot or Cold Intolerance	
		Unexpected Weight Loss/Gain	
		Hearing Loss, *explain:*	**HENT**
		Visual Disturbances	**Eyes**
		Cough	**Respiratory**
		Shortness of Breath	
		Chest Pain	**Cardiovascular**
		Palpitations/Racing Heart Beat	
		Black or Bloody Stools	**Gastrointestinal**
		Nausea/Vomiting	
		Change in Bowel Movements	
		List issues:	
		Frequent Urination	**Genitourinary**
		Enuresis *(Excessive Nighttime Urination)*	
		Spotting or Irregular Vaginal Bleeding	
		Genital Sore	
		Penile discharge/Pain swelling	
		Urinary Incontinence/Leakage	
		Menopause Symptoms	
		HIV Exposure	
		Risk for Sexually Transmitted Diseases (STDs)	
		Joint Pain/Swelling	**Musculoskeletal**
		Wound	**Skin**
		Frequent Headaches	**Neurological**
		Memory Loss	
		List *(bruising)*:	**Hematological**
		Nervous/anxious	**Emotional State**
		Blues/sadness	

Other: _____

Your doctor will review this list and let you know if a separate visit will be required to address the above symptoms.

Signature: _____ Date: _____