ADULT MEDICAL HISTORY FORM

Name _____ Date of Birth _____

MEDICATIONS: Please list any medications you currently take – include both prescription and non-prescription medicines, vitamins, home remedies, birth control pills, and herbs. If possible, list dose and frequency.

_____
_____
_____
_____

ALLERGIES: Please list any reactions to medicines/foods/other agents:

_____
_____
_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis)

_____ High Blood Pressure
_____ Diabetes
_____ Elevated cholesterol
_____ Lung disease
_____ Liver disease, hepatitis
_____ Arthritis
_____ Thyroid disease
_____ Sexually transmitted disease
_____ Depression
_____ Eczema, rash, hives
_____ Cancer (what kind?) _____
_____ Other (specify) _____

LIFESTYLE

Do you smoke? _____ No _____ Yes (how much?) _____
Do you drink alcohol _____ No _____ Yes (how much?) _____
Do you use street drugs? _____ No _____ Yes (what type?) _____
Do you exercise regularly? _____ No _____ Yes (what type?) _____

FAMILY HISTORY: Indicate if any family members have the following conditions:

Yes	No		Relationship	Yes	No		Relationship
_____	_____	Alcoholism	_____	_____	_____	Kidney trouble	_____
_____	_____	Arthritis	_____	_____	_____	Psychological problems	_____
_____	_____	Asthma, hives	_____	_____	_____	Stomach/bowel problems	_____
_____	_____	Bleeding disorder	_____	_____	_____	Thyroid problems	_____
_____	_____	Death before age 50	_____	_____	_____	Tuberculosis	_____
_____	_____	Diabetes	_____	_____	_____	Breast Cancer	_____
_____	_____	Epilepsy	_____	_____	_____	Colon Cancer	_____
_____	_____	Heart disease	_____	_____	_____	Prostate Cancer	_____
_____	_____	High blood pressure	_____	_____	_____	Other Cancer	_____
_____	_____	High Cholesterol	_____	_____	_____	Other problems	_____

Additional information: _____
_____

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and is protected by law.
NOTE: Any of the information in your Medical History could be requested by your insurance company as part of your medical records.

_____ _____
Signature Date