

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