New Adult Medical History

Name _____

Date of Birth _____

Date of Visit _____

Reason For Visit _____

_____

AFFINIA HEALTHCARE™

Inspired by the Patients We Serve

Past Medical History

Have you ever had any of the following?	No	Yes	Describe the problem: Dates: Medication, Hospitals, Results	For Medical Team Only
1. Anemia (low blood counts) or other blood problems	D	D		
2. Angina (heart pain) of Heart disease of Heart Valve Problems or Heart Attack or Coronary Heart Disease	D	D		
3. Astrial Fibrillation or heart arrhythmias	D	D		
4. High Blood Pressure	D	D		
5. High cholesterol or triglycerides	D	D		
6. Arthritis/Joint Pain	D	D		
7. Asthma	D	D		
8. Other lung problems – COPD	D	D		
9. Benign Prostatic Hypertrophy	D	D		
10. Blood Clots – DVT/PE	D	D		
11. Cancer	D	D		
12. Depression/Anxiety/Other	D	D		
13. Diabetes	D	D		
14. Heart Burn/GERD/Stomach Ulcers	D	D		
15. Liver/Hepatitis or Gallbladder problems	D	D		
16. Irritable Bowel/Crohns/Diverticulitis	D	D		
17. Osteoporosis	D	D		
18. Kidney or Bladder problems	D	D		
19. Seizures	D	D		
20. Stroke/TIA	D	D		
21. Thyroid problems	D	D		
22. Bone/Skin problems	D	D		
23. Eye/Ear problems	D	D		
24. Tuberculosis or positive tuberculin skin test	D	D		
25. If female, could you be pregnant?	D	D		
26. If female, when was the first day of your last period?	D	D		
27. Any problems with your period – heavy, irregular, pain? How long between periods? How many days does the bleeding last?	D	D		
28. Any abnormal pap tests/smears?	D	D		
29. Vaginal or Breast problems?	D	D		
30. Have you ever been pregnant? If yes, how many times – how many vaginal deliveries, how many csection, how many miscarriages, how many abortion, how many others			Total____ Miscarriages ____ Abortions____ Ectopics ____ Vaginal Deliveries____ C-sections_____ Preterm _____ Shoulder Dystocia _____ Blood Transfusion _____ Diabetes/High Blood Pressure during Pregnancy _____	

Screening History – Please give date, result, and location

1. Last cervical cancer screen/pap test?	
2. Last breast cancer screen/mammogram?	
3. Last colon cancer screen (stool card/colonoscopy)	
4. Last Diabetes Screen (A1C, Eye Exam, Foot Exam)?	
5. Last Lipid/Cholesterol screen?	

Past Surgical History

1. Please list any surgeries or operations – Include name of operation, date, location	

Past Social History

1. Ever smoked cigarettes or used tobacco products (chew, cigars) – If current or former use please indicate on the form, how many years used, when you quit, and how many per day?	
2. Alcohol/Drug Use – please list details if yes	

Past Family History

1. Family history (children, parents, siblings)	

Medications

Please list your pharmacy and the medications you take with the name, strength and how often: _____
_____

_____

Allergies to Medicines

Please list any medicines you are allergic to and what happens when you take it. _____
_____
_____

Doctors

Please list your last primary care doctor and any specialists you see with office number, fax (if known), and address. _____
_____
_____
_____
_____