

Personal, Family, Social History - ADULT

/ / ← Birthdate (MM/DD/YY) ← Age

| Medicines taken regularly | Reason |
|---------------------------|--------|
| | |
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| | |
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| | |

| If YOU have had | Year | Dr.s Use |
|---|------|----------|
| <input type="checkbox"/> Meningitis | | |
| <input type="checkbox"/> Valley fever | | |
| <input type="checkbox"/> Malaria | | |
| <input type="checkbox"/> Hives / Urticaria | | |
| <input type="checkbox"/> Venereal disease / STD | | |
| <input type="checkbox"/> Arthritis | | |
| <input type="checkbox"/> Rheumatic fever | | |
| <input type="checkbox"/> Heart murmur | | |
| <input type="checkbox"/> Loss of consciousness | | |
| <input type="checkbox"/> Blood clot | | |
| <input type="checkbox"/> Blood transfusion | | |
| <input type="checkbox"/> Hepatitis | | |
| <input type="checkbox"/> Hay fever | | |
| <input type="checkbox"/> Glaucoma | | |
| <input type="checkbox"/> Thyroid disease | | |

If YOU have had **Year** **Dr.s Use**
 Meningitis
 Valley fever
 Malaria
 Hives / Urticaria
 Venereal disease / STD
 Arthritis
 Rheumatic fever
 Heart murmur
 Loss of consciousness
 Blood clot
 Blood transfusion
 Hepatitis
 Hay fever
 Glaucoma
 Thyroid disease

Serious injury/burn (where): _____
 Broken bones (which): _____
 Hospitalization for (non-OB): _____
 Surgery to: _____
 Other significant history: _____

| Medication Problems | Reaction |
|---------------------|----------|
| | |
| | |
| | |
| | |

| NON-Medication Allergies | Reaction |
|--------------------------|----------|
| | |
| | |
| | |

| Immunizations | Year | Immunizations | Year |
|----------------------------|------|---------------|------|
| Tetanus | | Hepatitis A | |
| Influenza | | Hepatitis B | |
| Pneumonia | | Polio | |
| Whooping Cough / Pertussis | | | |

Tetanus _____ Hepatitis A _____
 Influenza _____ Hepatitis B _____
 Pneumonia _____ Polio _____
 Whooping Cough / Pertussis _____

Women

Age at first menses: _____ Age at menopause: _____
 Current cycle length (day 1 to day 1): _____ days.
 # of pregnancies: _____ # of miscarriages: _____ # of abortions: _____
 Current birth control method: _____
 Anticipate pregnancy in the next 3 years? Yes No
 Abnormal PAP smear? year: _____ Grade: _____
 How treated: _____
 How many subsequent normal PAP smears? _____
 Abnormal Mammogram? year: _____ Left Right

Men

How many children have you fathered? _____
 How many children are you actively relating to? _____

Name: _____ Date: _____

| If YOU or any Blood relative have had: |
|---|
| Please specify, Self, Fa, Mo, Bro, Sis, Son, Dau <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Repeated infections <input type="checkbox"/> Heart attack <input type="checkbox"/> Tuberculosis <input type="checkbox"/> High blood pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Severe allergies <input type="checkbox"/> Mental or emotional illness <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Seizures / tremors <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Diabetes <input type="checkbox"/> Gout <input type="checkbox"/> Significantly overweight <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Leukemia <input type="checkbox"/> Cancer of _____ <input type="checkbox"/> _____ <input type="checkbox"/> Alcohol / drug problems <input type="checkbox"/> Family violence / abuse |

Please specify, **Self, Fa, Mo, Bro, Sis, Son, Dau**
 Anemia
 Bleeding tendency
 Repeated infections
 Heart attack
 Tuberculosis
 High blood pressure
 Asthma
 Severe allergies
 Mental or emotional illness
 Suicide attempt
 Seizures / tremors
 Migraine headaches
 Diabetes
 Gout
 Significantly overweight
 Irritable Bowel Syndrome
 Leukemia
 Cancer of _____

 Alcohol / drug problems
 Family violence / abuse

| Personal Information | Fill In or Circle |
|----------------------|-------------------|
|----------------------|-------------------|

Birth place: _____ Years of school: _____
 Marital status: S M D W Partner Times married: _____
 Jobs held (start with most current): _____

Religion (heritage or current): _____

Importance to me: None Average Important Vital
 In an average **week** I exercise / work vigorously _____ hours.
 My compliance with a healthy diet is:
 Poor Fair Good Excellent
 I am sexually attracted to: men women both

On an average day I:
 smoke/use _____ cigarettes/cigars/cans of tobacco/snuff
 drink _____ oz. of beer _____ oz. of wine
 _____ oz. of liquor _____ oz. of coffee / tea

Wear seat belts almost all the time: Yes No
 Home has working smoke alarm: Yes No
 If over 30, approximate total Cholesterol: _____ mg / dl

Have you completed a:
 "Living Will" Yes No
 If so, where is it filed? _____
 "Power of Attorney for Health" Yes No
 If so, where is it filed? _____
 "Organ Donor Declaration" Yes No
 If so, where is it filed? _____

Whom do you share a home with?

| Name | Age | Relationship | Their health |
|------|-----|--------------|--------------|
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