The Physician Network

Antelope Creek Family Physicians

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Adult History Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Birthplace: _____

Marital Status: _____ Occupation: _____

Gender Noted on Birth Certificate: _____ Gender Identifies As: _____

Present Problems:

_____

_____

_____

Past Medical History:

ALLERGIES - List any allergies to medications, foods or other (i.e. bee stings).

_____ _____

_____ _____

MEDICATIONS - List any medications you are taking and the reason for taking them.

_____ _____

_____ _____

SURGERIES - List any operations you have had and the date performed.

_____ _____

_____ _____

MEDICAL PROBLEMS - List any major problem you have had and your age or the daate they first occurred.

_____ _____

_____ _____

INJURIES - List any major injuries and the date occurred.

_____ _____

_____ _____

HOSPITALIZATIONS - List the date and reason for any other hospitalizations.

_____ _____

_____ _____

Immunizations:

Did you have all your childhood immunizations? ☐ Yes ☐ No

Date of last tetanus immunization _____

Personal Habits:

Have you ever used (circle all that apply): Smoking Tobacco Chewing Tobacco Nicotine Vape Unit

When did you start? Quit? _____

Amount/frequency of use: _____

How much alcohol do you drink? ☐ Never ☐ Rarely ☐ Moderate ☐ Heavily

Usual type you consume? _____

How much each day or week? _____

How much caffeine do you drink each day? _____

Have you used street drugs? ☐ Yes ☐ No

Do you wear a seat belt? ☐ Never ☐ Rarely ☐ Occasionally ☐ Often

Family History:	***LIVING***		***DECEASED***	
	Age	Health	Age	Cause
Father				
Mother				
Siblings				
1.				
2.				
3.				
4.				
5.				
Children				
1.				
2.				
3.				
4.				
5.				

RELATIONSHIP			***RELATIONSHIP***	***AGE AT ONSET***
Heart attack	☐ Yes	☐ No		
Other heart problems	☐ Yes	☐ No		
High blood pressure	☐ Yes	☐ No		
Diabetes	☐ Yes	☐ No		
High cholesterol	☐ Yes	☐ No		
Stroke	☐ Yes	☐ No		
Severe arthritis	☐ Yes	☐ No		
Tuberculosis	☐ Yes	☐ No		
Hepatitis	☐ Yes	☐ No		
Epilepsy	☐ Yes	☐ No		
Psychiatric problem	☐ Yes	☐ No		
Alcoholism	☐ Yes	☐ No		
Thryoid problem	☐ Yes	☐ No		
Cancer	☐ Yes	☐ No		
Type				

Review of Systems:
Do you or have you had the following problems?

GENERAL

Anemia ☐ Yes ☐ No
Extreme tiredness or fatigue ☐ Yes ☐ No
Unexplained fever ☐ Yes ☐ No
Night sweats ☐ Yes ☐ No
Recent weight gain or loss ☐ Yes ☐ No
Loss of appetite ☐ Yes ☐ No
Excessive thirst or hunger ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Thyroid problems ☐ Yes ☐ No

HEAD

Skull fracture or trauma ☐ Yes ☐ No
Poor vision with glasses ☐ Yes ☐ No
Blurring vision ☐ Yes ☐ No
Double vision ☐ Yes ☐ No
Loss of vision ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Hard of hearing ☐ Yes ☐ No
Ringing of the ears ☐ Yes ☐ No
Frequent nose bleeds ☐ Yes ☐ No
Frequent nasal congestion ☐ Yes ☐ No
Fractured nose ☐ Yes ☐ No
Frequent sinus infections ☐ Yes ☐ No
Sores on lips or in mouth ☐ Yes ☐ No
Poor teeth ☐ Yes ☐ No
Dentures ☐ Yes ☐ No
Recurrent sore throat ☐ Yes ☐ No
Persistent hoarseness ☐ Yes ☐ No

HEART

Rheumatic fever ☐ Yes ☐ No
Heart attack ☐ Yes ☐ No
Angia ☐ Yes ☐ No
Chest pains or pressure with exertion ☐ Yes ☐ No
Chest pains or pressure at rest ☐ Yes ☐ No
Shortness of breath with minimal exertion ☐ Yes ☐ No
Shortness of breath while lying flat ☐ Yes ☐ No
Awakened at night short of breath ☐ Yes ☐ No
Number of pillows you use at night _____
Feet or ankle swelling ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
High cholesterol ☐ Yes ☐ No

LUNGS

Asthma or emphysema ☐ Yes ☐ No
Chronic cough ☐ Yes ☐ No
Coughing up blood ☐ Yes ☐ No
Frequent bronchitis ☐ Yes ☐ No
Pneumonia ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No

GASTROINTESTINAL

Difficulty swallowing ☐ Yes ☐ No
Food getting caught in esophagus ☐ Yes ☐ No
Heartburn ☐ Yes ☐ No
Hiatal hernia ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No
Chronic nausea ☐ Yes ☐ No
Vomiting blood or coffee grounds ☐ Yes ☐ No
Hepatitis or liver problems ☐ Yes ☐ No
Jaundice ☐ Yes ☐ No
Gallbladder problems ☐ Yes ☐ No
Chronic diarrhea ☐ Yes ☐ No
Chronic constipation ☐ Yes ☐ No
Pencil-like stools ☐ Yes ☐ No
Recent change in bowel habits ☐ Yes ☐ No
Blood in stools ☐ Yes ☐ No
Black tar-like stools ☐ Yes ☐ No
White chalky stools ☐ Yes ☐ No
Chronic abdominal pain ☐ Yes ☐ No

URINARY

Kidney or bladder infection ☐ Yes ☐ No
Kidney stone ☐ Yes ☐ No
Burning or pain urinating ☐ Yes ☐ No
Difficulty passing urine ☐ Yes ☐ No
Difficulty controlling urin ☐ Yes ☐ Noe
Frequently urinating ☐ Yes ☐ No
Getting up at night to urinate ☐ Yes ☐ No
Blood in urine ☐ Yes ☐ No

MUSCULOSKELETAL

Fractures or dislocations ☐ Yes ☐ No
Chronic back or neck pain ☐ Yes ☐ No
Ruptured disc ☐ Yes ☐ No
Degenerative or rheumatoid arthritis ☐ Yes ☐ No
Painful or swollen joints ☐ Yes ☐ No
Pain in leg, calf or buttock when walking ☐ Yes ☐ No
Bone or muscle pain ☐ Yes ☐ No
Blood clot or phlebitis ☐ Yes ☐ No

NEUROLOGIC

Frequent headaches ☐ Yes ☐ No
Frequent dizziness ☐ Yes ☐ No
Fainting ☐ Yes ☐ No
Epilepsy or seizures ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Weakness in arm or leg ☐ Yes ☐ No
Numbness ☐ Yes ☐ No
Slurred speech ☐ Yes ☐ No

PSYCHIATRIC

Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Difficult sleepin ☐ Yes ☐ No
Irritability ☐ Yes ☐ No
Suicide thoughts ☐ Yes ☐ No
Suicide attempt ☐ Yes ☐ No
Hearing voices ☐ Yes ☐ No
Difficulty concentrating ☐ Yes ☐ No
Difficulty with memory ☐ Yes ☐ No

SKIN

Acne ☐ Yes ☐ No
Frequent rash ☐ Yes ☐ No
Eczema ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No
Dry skin ☐ Yes ☐ No
Itching ☐ Yes ☐ No
Changing mole ☐ Yes ☐ No
Frequent skin infection ☐ Yes ☐ No
Skin ulcers ☐ Yes ☐ No
Sores that heal slowly ☐ Yes ☐ No
Frequent large lymph glands ☐ Yes ☐ No

GENITALIA — MEN

Impotence ☐ Yes ☐ No
Prostate problem ☐ Yes ☐ No
Venereal disease ☐ Yes ☐ No
Discharge from penis ☐ Yes ☐ No
Rash or sore on penis ☐ Yes ☐ No
Swelling of scrotum ☐ Yes ☐ No
Lump in testicle or scrotum ☐ Yes ☐ No
Hernia ☐ Yes ☐ No
Pain in testicle ☐ Yes ☐ No

GENITALIA — WOMEN

Breast lump ☐ Yes ☐ No
Discharge from nipples ☐ Yes ☐ No
Pelvic infection or venereal disease ☐ Yes ☐ No
Frequent vaginal infections ☐ Yes ☐ No
Ovarian cyst ☐ Yes ☐ No
Chronic pelvic pain ☐ Yes ☐ No
Irregular periods ☐ Yes ☐ No
Severe cramping with periods ☐ Yes ☐ No
Date of last pap smear _____
Abnormal pap smear ☐ Yes ☐ No
Age at onset _____
Date last period started _____
Menstrual cycle (start to start) _____ days
Duration of periods _____ days
Flow is: ☐ Light ☐ Medium ☐ Heavy
Total number of pregnancies _____
Number of full-term pregnancies _____
Number of premature deliveries _____
Number of miscarriages or abortions _____
Number of live births _____
C-section deliveries ☐ Yes ☐ No
Tubal ligation ☐ Yes ☐ No