ADULT MEDICAL HISTORY

Name _____ **Today's Date** _____

Date of Birth _____ **Height** _____ **Weight** _____

Do You Have A History Of :

Yes	No			Yes	No
		Anemia or Sickle Cell Disease	HIV Infection/AIDS		
		Arthritis or Back Problems	Heart Attack or Heart Failure		
		Asthma	Heart Murmur		
		Bleeding Tendencies	Heart Rhythm Abnormality		
		Blood Transfusions	Hepatitis, Liver Disease, or Cirrhosis		
		Clotting Problems	High Blood Pressure		
		Bowel Problems	Kidney Disease		
		Bronchitis, Pneumonia or TB	Seizures or Epilepsy		
		Emphysema/COPD	Stomach Ulcers		
		Cancer	Stroke or Mini-stroke		
		Chest Pain	Thyroid Abnormalities		
		Depression	Other:		
		Diabetes	Other:		
		Elevated Cholesterol	Other:		

List All Prior Surgeries:

Surgery	Date	Surgery	Date

List All Medications:

Medication	Strength	Frequency	Medication	Strength	Frequency

Name _____ **Today's Date** _____

List All Allergies to Medication

Medication	Reaction	Medication	Reaction

Does Anyone Related To You Have A History Of:

	Yes	No	Relationship
Prostate Cancer			
Kidney Disease			
Kidney Stones			
Cancer			
Anesthetic Problems			

Miscellaneous Information / Risk Factors

Do you smoke? Y / N How much _____ Date Began _____

Did you use to smoke? Y / N How much _____ Date Began _____ Date Quit _____

Do you drink? :

Alcohol	Y / N	How much _____
Coffee	Y / N	How much _____
Tea	Y / N	How much _____
Cola	Y / N	How much _____

Do you exercise? Y / N How much _____

Marital status: Married _____ Widowed _____ Divorced _____ Single _____

Children: _____
(names & ages)

_____

_____

_____

Hobbies: _____

Occupation: current: _____

prior: _____

_____