

Please complete as much as possible. On both pages. Thank You.

South Oaks Family Medicine, P.A.

ADULT HEALTH HISTORY (16 YEARS AND OLDER)

Name _____ D.O.B: ____/____/____ Sex: M F

Check all items that apply to you; fill in blanks as needed.

Past Medical History:

- | | |
|--|---|
| <input type="checkbox"/> Allergies (other than drugs) _____ | <input type="checkbox"/> Heart disease or heart attack |
| <input type="checkbox"/> Anemia or Blood problems | <input type="checkbox"/> Hepatitis, A B C or Jaundice |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Hypothyroid or Hyperthyroid |
| <input type="checkbox"/> Blood transfusion, what year _____ | <input type="checkbox"/> Inherited disease |
| <input type="checkbox"/> Cancer/Tumor, explain _____ | <input type="checkbox"/> Kidney disease or stone |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Mental illness or Depression |
| <input type="checkbox"/> Colon disease | <input type="checkbox"/> Pap smear, abnormal |
| <input type="checkbox"/> COPD, emphysema, lung disease | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Diabetes, type _____ how long _____ | <input type="checkbox"/> Sexually transmitted disease (STD) |
| <input type="checkbox"/> Drug or alcohol abuse | <input type="checkbox"/> Sickle cell anemia or trait |
| <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Skin disease, eczema, psoriasis |
| <input type="checkbox"/> Glaucoma or Cataracts | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches, type _____ | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Other _____ |

Past Surgical & Hospitalization History:

- | | | |
|--|--|--|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Hysterectomy(uterus) | <input type="checkbox"/> Ovaries removed |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Knee, R or L, procedure _____ | |
| <input type="checkbox"/> Back, procedure _____ | <input type="checkbox"/> Tonsillectomy | |
| <input type="checkbox"/> Breast, R or L, procedure _____ | <input type="checkbox"/> Tubal ligation (Tubes tied) | |
| <input type="checkbox"/> Cervical freezing or LEEP | <input type="checkbox"/> Vasectomy | |
| <input type="checkbox"/> Fracture _____ | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Hernia, R or L, type: _____ | <input type="checkbox"/> Other: _____ | |

Females Only: Age at first period _____ yrs. old Birth control method: _____
 Number of Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____
 Date of last. Period _____ Pap smear _____ Mammogram _____

Males Only: Date of last: Physical exam _____ Prostate exam _____ PSA _____

Drug allergies: No Known Drug Allergies

Name of Drug

Reaction

Current Medications: (prescription, over-the-counter, herbs, vitamins)

Medication Strength/Dose Frequency

Medication Strength/Dose Frequency

Immunizations/Year received:

- Tetanus booster
- Pneumovax
- TB Skin Test

- Flu Vaccine
- Hepatitis B
- Other

Social History:

Marital Status: Married Divorced Single Separated Widowed

Occupation: _____ Highest level of education: _____

Tobacco: Cigarettes Smokeless How much/day: _____; how long: _____ Quit, when _____

Alcohol: Number of drinks / bottles of beer per week: _____

Caffeine: Number of cups of coffee: _____/day, glasses of tea: _____/day, sodas: _____/day

Do you exercise regularly: _____

Sexually active: Yes No New partner in the last year: Yes No

Victim of abuse: Physical Sexual Mental Verbal Who is/was abuser: _____

Seat belt use: Yes No Firearms in home: Yes No Firearms locked-up: Yes No

Exposure to hazardous materials: _____ Military service: _____

Special diet or vegetarian: _____ Travel to foreign countries: _____

Family History:

	Living		Deceased	
	Age	Health status or illnesses	Age	Cause of death & illness
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Father's father	_____	_____	_____	_____
Father's mother	_____	_____	_____	_____
Mother's father	_____	_____	_____	_____
Mother's mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Children	_____	_____	_____	_____

Patient Signature: _____ Date: _____

Provider Review/Signature: _____ Date: _____