Western Medicine, Inc

Adult History Form

Name: ________________________________ DOB: _____________ Age: ________ Sex: ___ Male ___ Female

What name would you like to be called? ______________________________ Race: ____________________

Please check one ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

MEDICATIONS (Please include all prescriptions, over-the-counter, vitamins, and supplements)		
Name of Medication	Strength	Directions

ALLERGIES TO ANY MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? YES NO
(If yes, please list name of medication and type of reaction)

SURGERIES/HOSPITALIZATIONS – Please list date and details; circle either surgery or hospitalization for each		
	Date	Reason / Details
SURG / HOSP		
SURG / HOSP		
SURG / HOSP		
SURG / HOSP		
SURG / HOSP		
SURG / HOSP		
SURG / HOSP		
SURG / HOSP		
SURG / HOSP		

SEVERE INJURIES
Please list dates and details of any injuries you have ever had ____________________________________

IMMUNIZATIONS

Western Medicine, Inc

Date of last Tetanus vaccine? ________________ Date of last TB test ________________ POS NEG

Dates of Hepatitis B series? ________________ ________________ ________________

Date of last Influenza vaccine? ______________ Date of Pneumonia vaccine? ______________

List date of Zostavax vaccine? ________________

HEALTH MAINTENANCE

Date of your last colonoscopy? ______________ Date of your last pap smear? ______________

Date of your last mammogram? ______________ Date of your last bone density test (DEXA scan)? ______________

Date of your last eye exam? ______________ Date of last wellness exam? ______________

What kind of exercise do you do? ____ How often? ________________

Do you wear seat belts? YES NO Do you use sunscreen? YES NO

Do you drink coffee / soda / tea ? YES NO If yes, how many cups/cans a day? ________________

Which of the following conditions are you currently being treated for or have been treated for in the past?
Please check all that apply:

____ Abnormal EKG	____ Chronic Cough	____ Heart Murmur	____ Pancreatitis
____ Abnormal PAP	____ Depression	____ Hemorrhoids	____ Pneumonia
____ Acid Reflux	____ Diabetes	____ Hepatitis	____ Polio
____ Alcoholism	____ Diarrhea	____ Hernia	____ Rheumatoid Arthritis
____ Allergies/Hayfever	____ Dizziness	____ Herniated Disc	____ Seizures
____ Anemia	____ Drug Abuse	____ High Blood Pressure	____ Sickle Cell Disease
____ Anxiety	____ Drug Overdose	____ High Cholesterol	____ Sinus problems
____ Arthritis	____ Eczema	____ HIV/AIDS	____ Skin Problems
____ Asthma	____ Emphysema	____ Hodgkin's Dz	____ Sleep Difficulties
____ Back Pain	____ Erectile Dysfunction	____ Insomnia	____ STD
____ Blood Transfusions	____ Epilepsy	____ Kidney Disease	____ Stomach Pain
____ Breast Lump	____ Glaucoma	____ Kidney Stones	____ Stroke
____ Cancer	____ Gallbladder	____ Leukemia	____ Swelling
____ Chest Pain	____ Genital Herpes	____ Liver problems	____ Suicide Attempt
____ Colitis	____ Gout	____ Lung problems	____ Throat Problems
____ Cold Sores	____ Headaches	____ Lupus	____ Thyroid problems
____ Color Blindness	____ Hearing problems	____ Meningitis	____ Tuberculosis
____ Concussion	____ Heart Attack	____ Migraines	____ Ulcer Disease
____ Constipation	____ Heart Disease	____ OCD	____ Urinary Infections
____ COPD	____ Heart Failure	____ Panic Attacks	____ Varicose Veins

Other : ____

____

FAMILY HISTORY

Does anyone in the family have any history of the following?
Please list: *mother, father, maternal / paternal grandmother / grandfather, sibling*

High blood pressure ____
High cholesterol ____
Heart disease ____
Stroke ____
Diabetes ____
Thyroid disease ____
Cancer ____
Bleeding/clotting disorder ____
Allergies ____

Western Medicine, Inc

Asthma ______________________________
Liver disease ______________________________
Kidney disease ______________________________
Seizures ______________________________
Migraines ______________________________
Acid reflux ______________________________
Gastrointestinal disease ______________________________
Mental problems ______________________________
Alcohol problems ______________________________
Drug problems ______________________________
OTHER: ______________________________

____

SOCIAL HISTORY

Are you sexually active? YES NO If yes: Are your partners: Men Women Both

Do you use Birth Control? YES NO If yes: List type: ________________________________

Have you ever had a sexually transmitted disease? YES NO ________________________________

Do you smoke? YES NO How many per day? ________________ Have you smoked in the past? _________

Do you use other tobacco products? _____________________________ When? _____________

Do you drink alcohol? YES NO How much _______________ Per day Per Week

Have you ever had a problem with alcohol in the past? YES NO Explain ______________________________

Has anyone ever expressed concerns about your alcohol use? YES NO

Do you currently use any recreational drugs? YES NO What types? ________________________________

Have you ever had a drug problem in the past (prescription drug addiction/illegal drug use)? YES NO

OB/GYN HISTORY

Age of first menses: _________ Date of last period: __________ Do you suffer from PMS? YES NO

Have you ever had an abnormal pap? YES NO If yes, date and results _________________________________

Pregnancies: Total Number ____ Full Term _____ Miscarriages ____ Abortions ____ Premature ____ Tubal _____

Complications____