Adult Medical and Social History

Legal Name		
Preferred Name	**Date of Birth**	**Today's Date**
Occupation	**Employer**	
Spouse / Partner	**# of Children**	**Yrs. Education**

List Allergies and Reactions

☐ **None**

Surgeries and Hospitalizations:

	Date

Current Medications, Dosage and Frequency

(including over the counter, vitamins and herbal prep)

Medications	Dosage	Frequency

Family Status

Relationship	Alive	Deceased	Age at Death
Mother	☐	☐	
Father	☐	☐	
Sister	☐	☐	
Brother	☐	☐	
Daughter	☐	☐	
Son	☐	☐	
Other: (describe)	☐	☐	

You and Your Family Medical History

	Self	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol Abuse									
Drug Abuse									
Allergies, nasal / eye									
Arthritis									
Asthma									
Bleeding / Blood Disorder									
Blood Clot in Arm / Leg									
Cancer									
Depression									
Diabetes									
Gastrointestinal Problems									
Genetic Diseases /Birth Defects									
Genitourinary Problems									
Headaches / Migraines									
Heart Problems (attack /angina)									
High Cholesterol									
High Blood Pressure									
Kidney Disease									
Mental Illness									
Suicide Attempt									
Musculoskeletal Disorders									
Nervous System Disorders									
Obesity									
Osteoporosis									
Sickle Cell Anemia									
Stroke									
Thyroid Disease									
Tuberculosis									
Vision Problems									
Other: (describe)									

Adult Medical and Social History Continued

Substance Use					
Tobacco Use	**How Much**	**Years**	**Date Quit**	**Types**	
☐ Never					
☐ 2nd Hand				☐ Cigarette	☐ Snuff
☐ Quit				☐ Pipe	☐ Chew
☐ Yes				☐ Cigars	
Comment					
Alcohol Use	**How Much**	**Years**	**Date Quit**	**Type**	
☐ No					
☐ Quit					
☐ Yes				Bottles of beer	
☐ Yes				Glasses of wine	
☐ Yes				Shots / hard liquor	
Comments					

Substance Use		
Drug Usage	**How Much**	**Type**
☐ No		
☐ Quit		
☐ Yes		IV Drug Use
☐ Yes		Cocaine
☐ Yes		Crack
☐ Yes		Ecstasy
☐ Yes		Heroin
☐ Yes		LSD
☐ Yes		Marijuana
☐ Yes		Methamphetamine
☐ Yes		Other (describe)
Comments		

For Women and Men			
Sexual Activity	**Partners**	**STI Risk**	
☐ Not Currently	☐ Female	Do you use condoms to protect against sexually transmitted illness? ☐ Yes ☐ No	
☐ No	☐ Male	Number of sexual partners in the last 3 months _____	
☐ Yes	☐ Both	Number of sexual partners in the last 12 months_____	
Do you have any risk factors for HIV (STI's HIV+ partner, needle use, blood transfusion, bisexual partner, etc.) ☐ Yes ☐ No			
Do you have a history of any sexually transmitted illness?			
☐ HIV	☐ Chlamydia	☐ Hepatitis B	☐ HPV
☐ Syphilis	☐ Gonorrhea	☐ Herpes	☐ Other
Have you ever been a victim of physical or sexual abuse? ☐ Yes ☐ No			

Sexual History		
Are your sex partners: ☐ a person with a penis ☐ a person with a vagina		
What body parts do you use when you have sex? ☐ Penis ☐ Vagina ☐ Anus ☐ Mouth		
Has there been any change to your sexual desire	☐ Yes	☐ No
If yes, please describe the change:		

Adult Medical and Social History Continued

Sexual History continued:					
Birth Control / Protection (Current Method) **C** ☐ (Past Method) **P** ☐					
C ☐ **P** ☐ Condom	**C** ☐ **P** ☐ Pill		**C** ☐ **P** ☐ Diaphragm		
C ☐ **P** ☐ IUD/Paragard	**C** ☐ **P** ☐ Implant		**C** ☐ **P** ☐ Sponge		
C ☐ **P** ☐ Spermicide	**C** ☐ **P** ☐ Rhythm		**C** ☐ **P** ☐ Patch		
C ☐ **P** ☐ Injection	**C** ☐ **P** ☐ Cervical Cap		**C** ☐ **P** ☐ Withdrawal		
C ☐ **P** ☐ IUS/ Mirena	**C** ☐ **P** ☐ Vaginal Ring		**C** ☐ **P** ☐ Depo		
C ☐ **P** ☐ Dental Dam	☐ Surgical Type:				
Have you ever been tested for HIV	☐ Yes	☐ No	Would you like to be tested for HIV?	☐ Yes	☐ No
Do you have pain during intercourse?	☐ Yes	☐ No			
Do you have any questions or concerns about your sexual health?					
Is there anything else you would like your medical provider to know about you?					
Have you had any problem with any method of birth control? ☐ Yes ☐ No					
If Yes, please explain:					
Are you using birth control now? ☐ Yes ☐ No					

Menstrual / Pregnancy History: How old were you when you started having periods?			
☐ Never Pregnant	☐ Currently Pregnant	☐ Planning on becoming pregnant in the coming year	
Date last pregnancy ended:	# of Pregnancies:	# of Live Births:	# of Ectopic Pregnancies:
# of Elective/Therapeutic Abortions:	# of Miscarriages:	# of Living Children:	
Pre-menstrual dysphoric disorder: ☐ Yes ☐ No		When did your last menses start?	
Do you have cramps? ☐ Yes ☐ No	Bleeding: ☐ Light ☐ Medium ☐ Heavy	Spotting ☐ Yes ☐ No	
When was your last pap smear?			
Have you ever had an abnormal pap smear? ☐ Yes ☐ No			
If your pap was abnormal, how was this treated?			
If you were born between 1940 – 1970, did your mother take DES when she was pregnant with you? ☐ Yes ☐ No ☐ Don't Know			

Adult Medical and Social History Continued

Year You Last Had:							
Immunizations				**Tests / Exams**			
	Date		**Date**		**Date**		**Date**
☐ Flu Vaccine		☐ T.B. Test		☐ Eye Exam		☐ Bone Density	
☐ Tetanus		☐ Rubella		☐ Stool Blood Test		☐ Mammogram	
☐ Pneumonia		☐ Mumps		☐ Colonoscopy		☐ Cholesterol Test	
☐ MMR		☐ Tdap		☐ HIV test			
☐ HPV		☐ Measles		☐ Chlamydia / Gonorrhea Screen			
☐ Hep A/B							

Personal Concerns:		
	No	**Yes**
Have you been in the military?	☐	☐
Have you had a blood transfusion?	☐	☐
Do you have a caffeine concern?	☐	☐
Exposure to occupational hazards?	☐	☐
Exposure to hobby hazards?	☐	☐
Do you have sleep concerns?	☐	☐
Do you have concerns about stress?	☐	☐
Do you have concerns about weight?	☐	☐
Do you follow a special diet?	☐	☐
Do you have a back care concern?	☐	☐
Do you exercise?	☐	☐
Do you wear a bike helmet?	☐	☐
Do you use a seat belt?	☐	☐

Comments: