Adult Patient History Form

Please help us get to know you better by answering the questions on both the front and back of this form.

Name	Date of Birth

If you are being treated for any other illnesses or medical problems by another physician, please describe the problems and indicate the name of the physician treating you.

Illnesses or Medical Problems	Physician Treating You

ALLERGIES

Allergic to any medications?	No	Yes	List:
Adverse reaction to medications?	No	Yes	List:

MEDICATIONS

List all medications you currently take including prescription medications, over-the-counter medications and herbal remedies

1	5	9
2	6	10
3	7	11
4	8	12

PATIENT'S MEDICAL HISTORY

ILLNESS	X	Year	ILLNESS	X	Year	ILLNESS	X	Year
Eye or eyelid infection			Heart murmur			Migraine headaches		
Glaucoma			Other Heart			Epilepsy		
Other eye problems			Stomach ulcer			Head Injury		
Deafness			Diverticulosis			Stroke		
Bronchitis			Colitis			Convulsions, seizures		
Emphysema			Gout			Arthritis		
Pneumonia			Yellow jaundice			Cancer or tumor		
Allergies or asthma			Liver trouble			Bleeding tendency		
Tuberculosis			Hepatitis			Diabetes		
Other lung problems			Hernia			Psoriasis		
High Blood Pressure			Hemorrhoids			Mental Illness		
Heart Attack			Kidney/bladder			Other		
High Cholesterol			Kidney Stone					
Arteriosclerosis			Prostate Problem					

PATIENT'S SURGICAL HISTORY/ HOSPITALIZATION

Year	Type of Surgery	Hospital and city

FAMILY HISTORY

Check if there is a family history of the medical problems noted below

(mother, father, siblings, grandparents)

Problem	**Relationship To Patient**		**Problem**	**Relationship To Patient**
Cancer (specify)			Epilepsy	
Diabetes			Glaucoma	
Heart Disease			Stroke	
High blood pressure			Rheumatoid	

FAMILY STATUS

	Mother	Father	Siblings		Children	
Alive (Age)						
Deceased						

TOBACCO USE

Do you smoke cigarettes?	Yes	No	Quit
	# packs/day		# packs/day
	# years		# years
			Date quit:

ALCOHOL USE

Do you drink alcohol?	Yes	No	
	# of drinks/week		

DRUG USE

Do you use recreational drugs?	No	Yes	
Do you exercise regularly?	No	Yes	

SOCIOECONOMICS

Occupation					
Education	Elementary	High School	College	Graduate School	
Marital Status	Single	Married	Separated	Divorced	Widowed
Number of children					

Signs and Symptoms not covered above

Patient Signature: Date:

FOR OFFICE USE ONLY

Reviewed by:		Date