Wintergreen Medical Center ______________________________

Name *Date*

Adult Medical History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age _________ How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: ______________________________

Other concerns: ______________________________

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
____Recent fevers/sweats
____Unexplained weight loss/gain
____Unexplained fatigue/weakness

Eyes
____Change in vision

Ears/Nose/Throat/Mouth
____Difficulty hearing/ringing in ears
____Hay fever/allergies/congestion
____Trouble swallowing

Cardiovascular
____Chest pains/discomfort
____Palpitations
____Short of breath with exertion

Breast
____Breast lump
____Nipple discharge

Respiratory
____Cough/wheeze
____Coughing up blood

Gastrointestinal
____Heartburn/reflux
____Blood or change in bowel movement
____Nausea/vomiting/diarrhea
____Pain in abdomen

Genitourinary
____Painful/bloody urination
____Leaking urine
____Nighttime urination
____Discharge: penis or vagina
____Unusual vaginal bleeding
____Concern with sexual function

Musculoskeletal
____Muscle/joint pain
____Recent back pain

Skin
____Rash
____New or change in mole

Neurological
____Headaches
____Memory loss
____Fainting

Psychiatric
____Anxiety/stress
____Sleep problem

Blood/Lymphatic
____Unexplained lumps
____Easy bruising/bleeding

Endo
____Cold/heat intolerance
____Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? **Yes** **No**

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day

Do you take any controlled substances (Xanax, Percocet, etc.) at all? Yes No Name ______________________________

Allergies or reactions to medications: ______________________________

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A _________ Hepatitis B ___________ Influenza (flu shot) ____________ MMR __________ Pneumovax (pneumonia) _________

Meningitis _________ Tetanus (Td) _________ Varicella (chicken pox) shot or Illness ___________ Tdap (tetanus & pertussis) ________

HEALTH MAINTENANCE SCREENING TESTS:

Lipid profile? *Yes* *No* Date __________ Results? ______________________________

Colonoscopy? *Yes* *No* Date __________ Results? ______________________________

Mammogram? *Yes* *No* Date __________ Results? ______________________________

Pap Smear? *Yes* *No* Date __________ Results? ______________________________

Bone Scan? *Yes* *No* Date __________ Results? ______________________________

Men: PSA? *Yes* *No* Date __________ Results? ______________________________

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

____Heart disease:
(specify type) ____________________
____Cancer (type) ____________________
____Stroke

____High blood pressure
____Diabetes
____Asthma/Lung disease
____High cholesterol

____Thyroid problem
____Kidney disease
____Other: (specify):____________________
____Other: (specify):____________________

SURGICAL HISTORY: Please list all prior operations (with month/year):

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism ____________________
Cancer, specify type ____________________
Heart disease ____________________
Depression/suicide ____________________
Genetic disorders ____________________
Diabetes ____________________

High cholesterol ____________________
High blood pressure ____________________
Stroke ____________________
Bleeding or clotting disorder ____________________
Asthma/COPD ____________________
Other: ____________________

SOCIAL HISTORY

Tobacco Use:

Cigarettes Never Quit Date ____________________

Current Smoker: packs/day ________# of yrs ____________

Other Tobacco: Pipe Cigar Snuff Chew

Are you interested in quitting? No Yes

Alcohol Use:

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

Is your alcohol use a concern for you or others? No Yes

Drug Use:

Do you use any recreational drugs? No Yes

Have you ever had a problem with prescription drugs? No Yes

Have you ever used needles to inject drugs? No Yes

Sexual Activity:

Sexually active: No Yes Not currently(last year or so)

Current sex partner(s) is/are: same sex opposite sex both

Birth control method: ____________None needed__________

Have you ever had any sexually transmitted diseases (STDs)?
No Yes

Are you interested in being screened for sexually transmitted diseases? No Yes

OTHER CONCERNS

Caffeine Intake: None Coffee/tea/soda ________6 oz.cups/day

Weight: Are you satisfied with your weight? No Yes

Diet:

How do you rate your diet? Good Fair Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? No Yes

Exercise:

Do you exercise regularly? No Yes

What kind of exercise? ____________________

How long (minutes) ____________How often? ____________

If you do not exercise, why? ____________________

Safety:

Do you wear a bike helmet? Yes No

Is violence at home a concern for you? Yes No

Have you ever been abused? Yes No

Do you have a gun in your home? Yes No

Have you completed a living will? Yes No

Durable healthcare power of attorney? Yes No

Would you provide us with a copy please? Yes No

Social History: Occupation: ______________________________Employer: ____________________

Years of education/highest degree:__________Marital Status: Single Partner/Married Divorced Widowed Other: ____________________

Name of spouse: ____________________Children's names and ages:______________________________

WOMEN'S HEALTH HISTORY # pregnancies _____# term deliveries ______# preterm deliveries _______#abortions __________

miscarriages__________ # living children________Age at start of periods:______Age at end of periods: _______