Adult History Form – Canby Family Medicine

Providence Medical Group
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Patient Name:	Date of Birth:	Today's Date:	Gender: Male/Female

Social History:

Marital Status: ___________ Occupation: ____________________ Spouse's Occupation________________

Alcohol Use: Average # of drinks consumed per week: _________

Tobacco Use: Never Currently smoke ____ packs/day for ___ Years Quit? Y/N Year Quit ____

Use chewing tobacco? Y/N _______# of cans/week

Drug use: Never _______ Recent __________ Remote ________ Current ___________

Caffeine Use: Average number of drinks per day: **None** **Rare<1** **Moderate 1-2** **High >2**

Do you exercise? How often? ___________________ Type of exercise ________________________

Do you have a POLST? Y/N

Have you completed a Living Will or Advanced Directive? Y/N

Patient's medical History: Has patient ever had: (Circle all that apply)

Environmental Allergies
Alcohol/Drug Abuse
Anemia
Anxiety
Arthritis
Asthma
Blood Transfusion
Cancer
Cataracts
CHF
Clotting Disorder
COPD

Depression
Diabetes Mellitus
Emphysema
GERD
Glaucoma
Heart Murmur
HIV/AIDS
Hypertension
Kidney Disease
Meningitis

Myocardial infarction
Nerve/ Muscle Disease
Osteoporosis
Seizures
Sickle Cell Anemia
Stroke
Thyroid Disease
Tuberculosis
Ulcers

Immediate Family's Medical History:

____

____

(Please see reverse side)

List All Surgeries/Serious Illnesses/Hospitalizations:

____

____

Medication/Food Allergies:

Medication ______________________ Reaction ______________________________________

______________________ ______________________________________

Food ______________________ Reaction ______________________________________

______________________ ______________________________________

Dates of your Last:

Blood test/Cholesterol Level: ______________
Flu Shot: ______________
Prostate Check: ______________
Wellness Exam: ______________
Glaucoma Check: ______________
Colonoscopy/Sigmoidoscopy: ______________

EKG: ______________
Chest X-Ray: ______________
Mammogram: ______________
Tetanus Booster: ______________
Pneumovax: ______________
Skin Test for TB: ______________

Please list all your medications: Include: Medication – Dose – Frequency

1. ____
2. ____
3. ____
4. ____
5. ____

Anything else you would like your provider to know?

____

____

____

Females only:

Date of Last Menstrual Period if applicable: ______________
Last Pap Smear: _____________ Any abnormal paps? Y/N when? __________
Pregnancies: ______________ Number of living children: ________
Birth Control Method: ___________________
Heavy Bleeding? Y/N Describe: ____