MLK Community Medical Group

Patient Name: _____

Date of Birth: _____

PATIENT HISTORY FORM - ADULT

Date of Service: _____ Date of Birth: _____

Name: _____ Alias / Nicknames: _____

Main reason for visit:_____

MEDICAL HISTORY (note year diagnosed with details)

- ☐ Asthma _____
- ☐ Bladder/Kidney disorders _____
- ☐ Blood disorders _____
- ☐ Breast/GYN disorders _____
- ☐ Cancer _____ _____
- ☐ Chronic eye/ear/nose disorders _____
- ☐ Depression/Anxiety _____
- ☐ Diabetes _____
- ☐ Gastrointestinal disorders _____
- ☐ Heart disorders _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Lung/COPD/Emphysema _____
- ☐ Neurologic /Stroke/Seizure _____
- ☐ Prostate problems _____
- ☐ Skin disorders _____
- ☐ Thyroid disorders _____
- ☐ Other_____ _____

MAJOR SURGERIES (note year in space)

- ☐ Abdominal _____
- ☐ Appendix _____
- ☐ Breast _____
- ☐ Gall Bladder _____
- ☐ Heart _____
- ☐ Orthopedic _____
- ☐ Prostate _____
- ☐ Uterus / Ovary _____
- ☐ Other_____

OTHER CONCERNS

Weight: Is your weight a concern? ☐ Yes ☐ No

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Exercise: Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise?_____

How long (minutes)? _____ How often? _____

Safety: Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you fall frequently? ☐ Yes ☐ No

Have you completed a living will or durable power of attorney for health care? ☐ Yes ☐ No

SOCIAL HISTORY

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Occupation: _____

Years of education/highest degree: _____

Tobacco Use:

Cigarettes: ☐ Never ☐ Quit Year _____

☐ Current Smoker: Packs/day _____ # of years _____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Drink Caffeine: ☐ Yes ☐ No Cups/day _____

Alcohol Use: ☐ Yes ☐ No # Drinks/week _____

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

Drug Use:

Have you used any recreational drugs? ☐ Yes ☐ No

Have you ever used needles to inject drugs? ☐ Yes ☐ No

Sexual Activity:

Sexually active: ☐ Yes ☐ No ☐ Not currently

Current sex partner(s): ☐ Male ☐ Female

Birth Control method: _____ ☐ None needed

Have you ever had a sexually transmitted disease(s) (STD's)? ☐ Yes ☐ No

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

PAST TESTS	Y	N	Year last done
Bone Density Scan	☐	☐	_____
Colonoscopy	☐	☐	_____
Mammogram	☐	☐	_____
PAP test (female)	☐	☐	_____
PSA (prostate)	☐	☐	_____
Treadmill (heart)	☐	☐	_____

MEDICATION: (prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs)

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

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ALLERGIES OR REACTIONS TO MEDICINES / FOOD / OTHER AGENTS:

Medication	Reaction or Side Effect	Date

FAMILY HISTORY

Check all that apply	Mental Health Disorders	Alcohol Abuse	CANCER				Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Cause of death or major illness	ADULT IMMUNIZATIONS: Please note if you have had any of the following immunizations (Note Year) (Year)
			Breast	Colon	Prostate	Lung						
Father												Gardasil Y N
Mother												Hepatitis B: Y N
Maternal Grandfather												Influenza (yearly): Y N
Maternal Grandmother												Pertussis: Y N
Paternal Grandfather												Pneumonia: Y N
Paternal Grandmother												Shingles: Y N
Brothers												Tetanus: Y N
Sisters												

Women

Date of last menstrual period: _____

# of pregnancies: _____ # of children: _____

Pap Smear: ☐ Normal ☐ Abnormal Date _____

Mammogram: ☐ Normal ☐ Abnormal Date _____

Do you take any of the following:

Calcium:	☐ Yes	☐ No	☐ Past
Vitamin D:	☐ Yes	☐ No	☐ Past
Estrogen (Premarin):	☐ Yes	☐ No	☐ Past
Progesterone (Provera):	☐ Yes	☐ No	☐ Past

Men

Do you have any of the following problems:

Waking up at night to urinate?	☐ Yes	☐ No
Difficulty starting urine stream?	☐ Yes	☐ No
Sexual concerns (getting or keeping an erection)	☐ Yes	☐ No
Have you had an abnormal PSA test?	☐ Yes	☐ No

Mental Well-being

Have you felt down, depressed or hopeless during the past month?	☐ Yes	☐ No
Often having little pleasure in doing things during the past month?	☐ Yes	☐ No
Have you had difficulty doing common tasks lately?	☐ Yes	☐ No
Have you struggled recalling familiar words?	☐ Yes	☐ No

Rate your overall stress level: ☐ Low ☐ Medium ☐ High

Comments

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Provider Date