Advanced Primary Medicine

ADULT HEALTH HISTORY

Personal Information Date:_______________

Patient Name: ___________________________________ Birth Date: _____/_____/_____ Age: ____

Occupation ___________________ Marital Status: ______ Name of Partner/Spouse: ________________

Race: [ ] Asian [ ] Black or African American [ ] Native American [ ] White / Caucasian

[ ] Other: ____________

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:____

____

____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): ____

Preferred **Pharmacy**: ____

Date of Last Complete Physical Exam: _____________ Date of Last Blood Work: ____________________

Date of Last Colonoscopy: _______________ Date of Last Tetanus Shot: __________________________

For Females: Date of Last Menstrual Period: _________ Date of Last Pap Smear: __________________

History of Abnormal Pap (list date/s)? ____________ Date of Last: Mammogram: _____ DEXA: ______

Number of Pregnancies: ________ Miscarriages: ______ Terminations: _______ Living Children: _____

Method/s of Contraception: ____

ADVANCED PRIMARY MEDICINE

If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member when applicable:

ADD/ADHD		Type 1 or 2 Diabetes		Respiratory Disease	
Anemia		Fractures		Skin Disease	
Allergies/Hay Fever		Gynecological Disease		Stomach/Colon Disease	
Asthma		High Blood Pressure		Stroke	
Arthritis		High Cholesterol		Seizure Disorder	
Anxiety/Depression		Heart Attack		Thyroid Disorder	
Alcoholism		Kidney Disease		Sexually Transmitted Disease	
Blood Clots		Liver Disease		Other:	
Cancer, Type/s		Neurological Disease		____________________	
____________________		Osteopenia/Osteoporosis			
		____________________			

Please list any **SURGERIES** you have had and include the month/year:

____

____

____

____

Social Information

Tobacco Use: Current smoker_____ Former smoker ______ Never_______ Chewing tobacco______

How many cigarettes daily? ______ How many years have you been using tobacco? __________

Alcohol Use: Do you drink alcohol? ____ If so, what type? ________How many drinks per week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? __________

Do you **exercise**? _____ What activities do you do, and how often in 1 week?_____________________

____

Are you on any special **diet**? _____ If so, what? ____

Do you consume any **caffeinated** products? _____ If so, what and how much per day? ______________

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities? _____

Do you have a living will? _____ If yes, please provide us a copy