

BROADLANDS FAMILY PRACTICE CENTER

Adult History Form

Name: _____ DOB: _____ Age: _____ Sex: ___ Male ___ Female
What name would you like to be called? _____ Race: _____ Religious preference: _____
Please check one ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Who do you currently live with? ___ Alone ___ Family ___ Friends ___ Significant other
Do you feel safe at home? YES NO
Current job: _____ Previous job: _____ Highest level of education? _____

MEDICATIONS (Please include all prescriptions, over-the-counter, vitamins, and supplements)

NAME/DOSE OF MEDICATION	REASON FOR TAKING MEDICATION

ALLERGIES TO ANY MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? YES NO
(If yes, please list name of medication and type of reaction)

SURGERIES/HOSPITALIZATIONS – Please list date and details; circle either surgery or hospitalization for each

DATE	SURG/HOSP	REASON/DETAILS
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	

SEVERE INJURIES
Please list dates and details of any injuries you have ever had _____

IMMUNIZATIONS
Date of last Tetanus vaccine? _____ Date of TB screening? _____ POS NEG
Date of Hepatitis B series? _____ Date of chicken pox disease or shot? _____
Date of last Pneumonia vaccine? _____ Date of last Flu vaccine? _____
Date of Gardasil series? _____

HEALTH MAINTENANCE
Date your last colonoscopy? _____ Date of your last pap smear? _____
Date of your last mammogram? _____ Date of your last bone density test? _____
Date of your last eye exam? _____ Date of last wellness exam? _____
Do you consider yourself Underweight Normal weight Overweight Obese
What kind of exercise do you do? _____ How often? _____
Do you wear seat belts? YES NO Do you use sunscreen? YES NO
Do you feel safe at home? YES NO Do you text while driving? YES NO
Do you drink coffee/soda/tea? YES NO If yes, how many cups/cans a day? _____
What type of birth control is used between you and your partner? _____

Which of the following conditions are currently being treated or have been treated for in the past?

- | | | | | |
|--------------------------------------------------------|-----------------------------------------------|--------------------------------------------|----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Back pain | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Concussion | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Drug overdose/abuse | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Gout | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herniated disk |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Heart failure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hodgkin's | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Lupus | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Muscle disease | <input type="checkbox"/> OCD | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Polio | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> STD _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Skin disease | <input type="checkbox"/> Sinus disease | <input type="checkbox"/> Suicide attempt | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Tuberculosis/Positive TB test | | <input type="checkbox"/> Ulcer disease | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Other _____ |

FAMILY HISTORY – Please put a checkmark in all applicable boxes

Were you adopted? YES NO

Illness	Father	Mother	Sibling	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Heart disease									
High cholesterol									
High blood pressure									
Diabetes									
Heart Attack									
Stroke									
Kidney disease									
Liver disease									
Bleeding/Clotting disorders									
Asthma									
Anemia									
Colon/Bowel problems									
Breast cancer									
Skin cancer									
Prostate cancer									
Lung cancer									
Ovarian cancer									
Other cancer									
Glaucoma									
Thyroid disease									
Drug/alcohol addiction									
Depression/Anxiety									
Suicide									
Seizures/Epilepsy									
HIV/AIDS									
Other:									

OB/GYN HISTORY

Age of first menses: _____ Date of last period: _____ Do you suffer from PMS? YES NO
 Have you ever had an abnormal pap? YES NO If yes, date and results _____
 Pregnancies: Total Number _____ Full Term _____ Miscarriages _____ Abortions _____ Premature _____ Tubal _____
 Complications _____

SOCIAL HISTORY

Are you sexually active? YES NO If yes, are your partners? MEN WOMEN BOTH
 Have you ever had a sexually transmitted disease? YES NO Diagnosis: _____
 Do you smoke? YES NO How many per day? _____ Have you ever quit? YES NO
 Do you use other tobacco products? _____ When? _____
 Do you drink alcohol? YES NO How many per day? _____ How many per week? _____
 Have you ever had a problem with alcohol in the past? YES NO Explain _____
 Has anyone ever expressed concerns about your alcohol use? YES NO Explain _____
 Do you currently use any recreational drugs? YES NO What types? _____
 Have you ever had a drug problem in the past (prescription drug addiction/illegal drug use)? YES NO
 If yes, explain _____