UNIVERSITY FAMILY MEDICINE CENTER, PA.

Adult Medical History

Name_____ Date of Birth _____Age_____

1). Last time you had a complete physical? (Including EKG, X-ray, Lab Work) _____
List any other physicians who provided you with routine medical care _____

2). Please circle if you now have (or in the past had) any of the following:

Epilepsy	Pulmonary Emboli	Colon/ Bowel Trouble	Bleeding Disorder
Fainting Spells	_____	Gallbladder Disease/ Surgery	Easy Bruising
Migraine/ Headaches	Eczema/ Skin Cancer	Hemorrhoids/ Piles	_____
Stroke	_____	Hepatitis/ Liver Disease	Arthritis
_____	Angina	Stomach/ Duodenal Ulcers	Broken Bones
Allergies/ Hayfever	Bypass Surgery	_____	Neck/ Back Problems
Glaucoma/ Cataracts	Circulatory Problems	Bladder Infections	_____
Hearing Trouble	Heart Trouble	Kidney Infections	Drug/ Alcohol Problems
Recurring Ear Infection	Heart Murmer	Kidney Stones	AIDS/ HIV Positive
Sinus Trouble	Palpitations	Prostate Trouble	Cancer
_____	Rheumatic Fever	_____	Depression
Asthma	Pacemaker	Diabetes mellitus	Anxiety
Emphysema	High Blood Pressure	Gout	Suicide
Recurring Bronchitis	Mitral Valve Prolapse	Thyroid Problems	Chronic Fatigue
Tuberculosis/ +TB Test	High cholesterol/ Triglycerides	_____	_____

Previous Surgery _____

3). FEMALES ONLY:

Pregnancies _____ Children _____ Miscarriages _____ Abortion _____
Last Pap Smear _____ Last Mammogram _____
Please circle if you now have (or in the past had) any of the following:

Breast Surgery	Fibrocystic Breast Disease	Menstrual Difficulties	PMS
D & C	Gonorrhea/ Syphilis/ Chlamydia	Ovarian Cysts	Tubal Ligation
Endometriosis	Hysterectomy	PID/ Pelvic Infections	Abnormal Paps

4). ALLERGIES: Circle any of the following allergies you have:

Penicillin Erythromycin Sulfa Tetracyclines Codeine Aspirin
Ibuprofen (NSAI's) Other _____

5). MEDICATIONS: List ALL the medications you are currently taking or have taken in the past month.

_____
_____
_____

6). SOCIAL HISTORY:

Do you smoke? YES NO How Much? _____ If you quit, when? _____
Do you drink alcohol/ beer? YES NO How Much? _____ If you quit, when? _____
Do you drink coffee tea? YES NO How Much? _____ If you quit, when? _____
Do you or have you ever abused prescription drugs or used street drugs? YES NO What drugs? _____

7). DIET: Regular____ Low fat/ Low Cholesterol ____ Vegetarian ____ Diabetic ____ Low Salt____
Weight Reduction ____ Other Type _____

8). EXERCISE: Regularly_____ Occasionally _____ Not at all _____

9). FAMILY HISTORY: Circle if the following health problems occur in your family:

Alcoholism	Bleeding Disorders	Emphysema	High Blood Pressure	Suicide
Allergies	Cancer	Epilepsy/ Seizures	High Cholesterol	Ulcer Disease
Anemia	Depression	Heart Attacks	Leukemia	Other _____
Asthma	Diabetes	Heat Trouble	Strokes	_____

	Age	Deceased Age	List Any Health Problems	Cause of Death
Father				
Mother				
Brother				
Sister				