Adult Health History - Medical

Raphael Health Center

Patient_____ Date of Birth_____

What is the reason for today's visit?_____

Medications

Drug Name	Strength or dose	How many times a day?

Allergies

Name of medication or trigger	What happens when you take it? (rash, vomiting, weakness, etc.)

Family History

Circle 'No' if none of the family members listed has had the medical condition listed. Circle 'Yes' if a family member has had a condition listed below and circle the family member(s) that have had the problem

Born with heart problem	Yes or No	Mother	Father	Brother	Sister	Child
Diabetes	Yes or No	Mother	Father	Brother	Sister	Child
Heart attacks	Yes or No	Mother	Father	Brother	Sister	Child
Heart operations	Yes or No	Mother	Father	Brother	Sister	Child
High blood pressure	Yes or No	Mother	Father	Brother	Sister	Child
High cholesterol	Yes or No	Mother	Father	Brother	Sister	Child
Stroke	Yes or No	Mother	Father	Brother	Sister	Child
Other:		Mother	Father	Brother	Sister	Child
Other:		Mother	Father	Brother	Sister	Child
Other:		Mother	Father	Brother	Sister	Child

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Social History:

Do you use tobacco products? ☐ Yes ☐ No
If yes, circle the type used: cigarettes, cigars, smokeless, e-cigarettes
Do you use illegal drugs? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
Are you employed? ☐ Yes ☐ No
Do you exercise at least 5 times a week? ☐ Yes ☐ No

Health problems-circle the problems that you have or have had in the past:

Artificial Heart Valves
Anemia
Arthritis
AIDS/HIV
Asthma
Autoimmune disease Mental Health problems
Blood transfusion (Date: _____)
Cancer: Radiation or Chemotherapy
Chronic pain (location: _____)
Diabetes
Emphysema or COPD:
Epilepsy or seizures
Heart Disease
Heart Infection
Hepatitis A, B, C
High blood pressure
Kidney problems
Liver Disease
Neurologic problems
Pacemaker or Defibrillator
Rheumatoid arthritis
Sexually transmitted diseases
Stroke
Thin bones/other bone problems
Tuberculosis (TB)
Thyroid problems
Ulcers

Hospitalizations

Have you ever been hospitalized in the last 5 years? ☐ Yes ☐ No
If yes, please list reasons for any hospitalizations and the date(s)

_____ ___/___/____ _____ ___/___/___

_____ ___/___/____ _____ ___/___/___

Surgeries

Have you ever had a surgery? ☐ Yes ☐ No Have you had a joint replacement? ☐ Yes ☐ No
If yes, please list any surgeries you have had and the date(s)

_____ ___/___/____ _____ ___/___/____

_____ ___/___/____ _____ ___/___/____

Females (List the dates) Are you currently pregnant? ☐ Yes ☐ No
Last menstrual period? __/__/____ Last pap smear? __/__/____ Last mammogram?__/__/____