Northwest PRIMARY CARE

Adult Medical History Form

Legal Name: _____ Former Name (if any): _____ DOB: _____ Date: _____

Preferred Name: _____ Pronoun(s): _____ Gender: _____

Marital Status: S M W D **Partner**

Occupation: _____

If retired, previous occupation: _____

Household (who lives in your household?):

List allergies/intolerances to medications:

Personal Medical History: Circle Yes or No, explain yes answers (when occurred or was diagnosed)		
Alcoholism	Y	N
Anxiety Disorder	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Bleeding tendency	Y	N
Blood clot	Y	N
Cholesterol (high)	Y	N
Cancer	Y	N
Depression	Y	N
Diabetes	Y	N
Emphysema/COPD	Y	N
Epilepsy	Y	N
Exposure to asbestos	Y	N
Exposure to TB	Y	N
Glaucoma	Y	N
Hayfever	Y	N
Heart disease	Y	N
Hepatitis (yellow jaundice)	Y	N
High blood pressure	Y	N
Kidney disease	Y	N
Kidney stone	Y	N
Migraines	Y	N
Osteoporosis	Y	N
Pneumonia	Y	N
Polio	Y	N
Recurrent bladder infection	Y	N
Rheumatic fever	Y	N
Sleep Apnea	Y	N
Stroke	Y	N
Thyroid disease	Y	N
Tuberculosis	Y	N
Ulcer	Y	N
Other serious illness	Y	N

Please list all surgeries with dates.	
Surgery	Date:

FORM CONTINUES ON THE OTHER SIDE

Adopted?	Y	N

Family History (Blood Relatives)		
If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death.		**Age at Death**
Father		
Mother		
Maternal Grandparents		
1		
2		
Paternal Grandparents		
1		
2		
Brothers and Sisters		
1		
2		
3		
4		
Children		
1		
2		
3		
4		
Number of Pregnancies (If applicable)		
Number of Births (If applicable)		

Health Maintenance (answer applicable questions)			
Have you had a pap smear? (If YES list date of last)	Date:		N
Have you had a mammogram? (If YES list date of last)	Date:		N
Have you had a bone density test?	Date:		N
Have you had a colonoscopy?	Date:		N
Do you have a Living-Will / Advance Directive?		Y	N

Immunizations (If YES list date of last)			
Have you had a tetanus vaccine?	Date:		N
Have you had a pneumonia vaccine?	Date:		N

Safety/Social Habits (please circle answers)				
Do you drink alcohol?	Y	N	Past	
If so, how much per day?				
Do you use tobacco?	Y	N	Past	
If so, how much per day?				
If used in the past: Start Date:		End Date:		
Are you exposed to secondhand smoke in your home?	Y	N	Past	
Do you use caffeine? (circle) coffee tea soda energy-drinks				
If so, how much per day?				
Do you use "recreational drugs"?	Y	N	Past	
If yes, what do you use?				
Are you sexually active?	Y	Not Currently	Never have	
What gender(s) are you attracted to?				
What do you do for exercise?				
How often do you exercise?				
Have you ever been abused?	Physically	Mentally	Sexually	
Are you satisfied with your weight?			Y	N
Do you always wear a seatbelt?			Y	N
If you ride a bike or motorcycle, do you always wear a helmet?			Y	N
Are guns kept in your home?			Y	N
If yes, is household aware of gun safety?			Y	N

Legal Name:_____ DOB: _____ Date: _____

Review of Systems

Do you **now have**, or have you **recently had** problems related to the following systems? Circle Yes or No. Please explain any Yes answers in the space provided.

Constitutional Symptoms		
Fever	Y	N
Chills	Y	N
Headache	Y	N
Weight loss/gain	Y	N
Other:	Y	N
Ear/Nose/Throat/Mouth		
Ear symptoms	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other:	Y	N
Hematologic/Lymphatic		
Swollen glands	Y	N
Easy bruising	Y	N
Other:	Y	N
Cardiac		
Chest Pains	Y	N
Irregular heartbeats	Y	N
Other:	Y	N
Respiratory		
Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other:	Y	N
Gastrointestinal		
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Black or bloody stools	Y	N
Diarrhea	Y	N
Other:	Y	N

Genitourinary		
Painful urination	Y	N
Urinary incontinence	Y	N
Blood in urine	Y	N
Other:	Y	N
Dermatologic		
Skin rash	Y	N
Mole change	Y	N
Other:	Y	N
Gynecologic		
Pelvic pain	Y	N
Irregular periods	Y	N
Painful periods	Y	N
Vaginal discharge	Y	N
Other:	Y	N
Musculoskeletal		
Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other:	Y	N
Endocrine		
Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other:	Y	N
Psychologic		
Do you have depressed feelings?	Y	N
Have you considered suicide?	Y	N
Sleep disturbance?	Y	N
Other:	Y	N

Please explain any YES answers

What do you do for fun?

Practitioner Use Only: (comments/notes)

# Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Practitioner: _____ Date:_____