ADULT DATABASE: MEDICAL HISTORY

PATIENT'S NAME **AGE:** **DATE:**

MEDICAL HISTORY	Self Yes	Family Yes
Heart Attacks		
Serious Heart Trouble		
High Blood Pressure		
Strokes		
Leukemia		
Other Cancer		
Diabetes (High Sugar)		
Thyroid Disease / Goiter		
Glaucoma		
Migraine Headaches		
Motion Sickness		
Cataracts		
Color Blindness		
Alcoholism / Alcohol Abuse		
Anemia (Low Blood Count)		
Easy Bleeding Problem		
Epilepsy (Seizures)		
Mental / Nervous Disorder		
Tuberculosis / Exposure to TB		
Pneumonia		
Emphysema		
Influenza		
Blood Clot to Lung		
Pleurisy		
Stomach Ulcer		
Gallbladder Disease		
Hepatitis / Yellow Jaundice		
Liver Disease / Cirrhosis		
Colitis / Other Bowel Disease		
Hemorrhoids / Rectal Problems		
Hernia		
Kidney Disease		
Nephritis (Kidney Infection)		
Cystitis (Bladder Infection)		
Prostate Trouble (Men)		
Gonorrhea or Syphilis		
Arthritis or Rheumatism		
Any Bone or Joint Disease		
Rheumatic Fever		
Polio or Meningitis		
Hay Fever or Asthma		
Hives or Eczema		
Any Other Disease?		

OB / GYN

No. of Pregnancies _____ Live Births _____

C-Sections? _____ Premature Babies? _____

Miscarriages? _____ Any Abortions? _____

Past Menopause ("The Change") _____ When? _____

Problems with any pregnancy? _____

_____

_____

_____

SURGERIES

Have you ever had surgery or been operated on for:	Yes	Year
Skin Cancer		
Appendix		
Tonsils		
Gallbladder		
Hernia		
Hemorrhoids		
Breast / Lump		
Female Organs		
Prostate		

OTHER HOSPITALIZATIONS

Reason	Year

PERSONAL HISTORY

Have you ever had:	Yes
Measles 3-Day (Rubella)	
Measles 10-Day	
Mumps	
Chicken Pox	
Scarlet Fever / Scarlatina	
Mononucleosis ("Mono")	
Allergies to:	
Penicillin	
Sulfa	
Any Other Medicine	
Any Foods	
Any Other Allergies	
Food / Chemical / Drug Poisoning	
Blood or Plasma Transfusion	
Broken or Cracked Bones	
Sprains or Dislocations	
Lacerations Needing Sutures	
Concussion or Head Injury	
Injury to Eye or Ears	
Use of: Hearing Aid	
Removable Dentures	
Glasses / Contacts	
Recommended Surgery Which	
Has NOT Been Done?	

Smoking: _____ /Day _____ No. of Years

Snuff _____ Chewing Tobacco _____

Beverages: Amount / Week ____ Liquor ____ Beer

____ Wine ____ Coffee ____ Sodas