

Piper Family Medicine, PC

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Adult Medical History Form

Patient Name: _____ Birth Date: _____ Today's Date: _____

Personal Medical History: (Please include even if under control with medication)							
	Yes	No	Comments				
Diabetes							
High Blood Pressure							
High Cholesterol							
Thyroid Problems							
Liver Problems							
Kidney Problems							
Heart Disease (specify)							
Stroke							
Asthma							
COPD							
Acid Reflux							
Peptic Ulcer Disease							
Depression							
Anxiety							
Cancer							
Other (specify)							
Women Only:							
	Yes	No	How many		Yes	No	How many
Pregnancy				Elective Abortions			
Live Births				Ectopic Pregnancy			
Miscarriages				Regular Cycles			
Vaccinations:							
Tetanus Date:			Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No				
Pneumonia Date:			Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No				
Pertussis/Whooping Cough Date:			Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No				

Current Medications and Dosages:

Medication Allergies and Reactions:

Surgical/Procedural History and Dates:

Personal Social History:				
	Yes	No	Frequency	Number of years
Currently use tobacco				
Formerly used tobacco				How many years: Quit:
Use illegal drugs				How many years: Quit:
Drink caffeine			How many per day:	
Exercise			Times per week:	
Drink alcohol			How many per day:	

Family Medical History: Please list any major ongoing medical problems (specifically high blood pressure, heart disease, stroke, diabetes, cancer and any other pertinent conditions), and if applicable, age at death and cause of death.

Mother/Mother's side of the family:

Father/Father's side of the family:

Siblings:

Review of Systems:			
Do you have problems with?	Yes	No	Please explain
Head			
Eyes			
Ears			
Nose			
Throat			
Neck			
Chest/Lungs			
Stomach			
Kidneys/Bladder			
Bowels			
Reproductive Organs			
Arms/Hands			
Legs/Feet			
Muscles/Joints			
Skin			
Back/Spine/Nerves			
Others			

Main Objective of Today's Visit: Out of all of your health questions and concerns, what would you like to be addressed most with today's visit?
