ORION
Family Physicians

ADULT MEDICAL HISTORY FORM

NAME: (print)_____D.O.B._____

Signature_____Date_____

E-mail_____

MEDICAL HISTORY

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	Y	N		Y	N
ALLERGIES (SEASONAL)			GLAUCOMA		
ANEMIA			HEADACHES/MIGRAINES		
ANXIETY			HEART ATTACK		
ASTHMA			HEARTBURN (ACID REFLUX)		
ARTHRITIS			HEART DISEASE (CLOGGED ARTERIES)		
CATARACTS			HEART MURMUR		
CANCER: TYPE			HIGH BLOOD PRESSURE		
CHRONIC ABDOMINAL PAIN			HIGH CHOLESTEROL		
CHRONIC CONSTIPATION			IRREGULAR MENSTRUATION		
CHRONIC DIARRHEA			KIDNEY PROBLEMS		
CHRONIC NAUSEA			LIVER PROBLEMS		
CHRONIC VOMITING			SEIZURES		
CONGESTIVE HEART FAILURE			STROKE		
COPD/EMPHYSEMA			THYROID PROBLEMS (OVERACTIVE OR UNDERACTIVE)		
DEPRESSION					
DIABETES MELLITUS					

OTHER CONDITIONS NOT LISTED ABOVE:_____

SURGICAL HISTORY

TYPE	DATE

ALLERGIES: NONE OR _____

MEDICATIONS

PLEASE INCLUDE OVER THE COUNTER MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS

MED	DOSE	TIMES TAKEN/DAY

over ➥

FAMILY HISTORY

	Y	N	RELATIVE (MOTHER, FATHER, SISTER, BROTHER, GRANDMOTHER, GRANDFATHER, CHILD)
ASTHMA			
DIABETES			
HEART DISEASE (CLOGGED ARTERIES)			
HEART ATTACK (INCLUDE AGE)			
HIGH CHOLESTEROL			
HIGH BLOOD PRESSURE			
THYROID PROBLEMS			
CANCER (WHAT TYPE)			
STROKE			
ALZHEIMERS			
DEPRESSION/ANXIETY			
MIGRAINE			

SOCIAL HISTORY

SMOKER: YES OR NO
IF YES HOW MUCH DO YOU SMOKE _____
IF FORMER SMOKER: HOW MUCH_____HOW LONG_____QUIT DATE_____

ALCOHOL USE: YES OR NO
IF YES HOW MANY DRINKS _____DAY OR _____WEEK

CAFFEINE INTAKE: YES OR NO
IF YES HOW MANY DRINKS_____DAY (8 OZ SERVINGS)
WHAT DO YOU DRINK: COFFEE TEA POP

ILLICIT DRUG USE: YES OR NO

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

OCCUPATION_____

CHILDREN: YES OR NO
IF YES HOW MANY? _____

DEPRESSION SCREENING

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More Than 1/2 The Day**	**Nearly Every Day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

HEALTH MAINTENANCE

	DATE
ANNUAL EYE EXAM	
BONE DENSITY TEST (OSTEOPOROSIS SCREENING)	
COLONOSCOPY: NORMAL: YES OR NO WHEN WERE YOU DUE BACK? 2 3 5 7 10 YEARS	
FLU VACCINE	
MAMMOGRAM	
MONTHLY SELF BREAST EXAM	Y OR N
PAP SMEAR: DO YOU HAVE A HISTORY OF ABNORMAL PAP? Y OR N	
PNEUMONIA VACCINE	
PROSTATE BLOOD TEST (PSA)	
TETANUS/PERTUSSIS VACCINE	
SHINGLES VACCINE	
CARDIAC STRESS TEST	
RECTAL EXAM FOR COLON CANCER SCREENING	
CHEST X RAY	
DENTAL EXAM	
EKG	