Piper Family Medicine, PC

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Adult Medical History Form

Today's Date: ____________________________________

Patient Name: ____________________________________ Date of Birth: _____________________________

Personal Medical History (Include all conditions, even those controlled by 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 ◯ Yes ◯ No
Pneumonia Date:	Hepatitis A ◯ Yes ◯ No
Pertussis/Whooping Cough Date:	Hepatitis B ◯ Yes ◯ No

Current Medications & Dosage:

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____
____
____
____
____

Medication Allergies & Reactions:

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____
____

Surgical/Procedural History & Dates:

____
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____
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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 family:	**Father/Father's side of family:**	**Siblings:**
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

Review of Systems:			
Do you have problems with:	Yes	No	Please explain
Ears			
Eyes			
Nose			
Throat			
Head			
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: Of all your health questions and concerns, what would you most like to be addressed during today's visit?