OSTEOPATHIC
FAMILY WELLNESS CENTER

Adult Medical History Form

Name: _____ **DOB:**_____

Is this your first visit to Osteopathic Family Wellness Center? ☐ Yes ☐ No

How did you hear about us? _____

Reason for Today's Visit: _____

Medical History

Allergies:

Drug Allergies: (Penicillin, Acetaminophen, Sulfa Drugs, NSAIDS, Ibuprofen) _____

Food: (Dairy, Egg, Peanuts, Shellfish, Soy, Wheat, Melon, Gluten) _____

Environmental: (Dust, Pollen, Animal Dander, Insects) _____

Contact: (Latex)_____

Medications: Please list all medications you currently take: Prescriptions, Vitamins, Supplements, Herbs

Family History:

Disease	Who Had it?	Disease	Who Had it?
ADHD/ADD		Epilepsy	
Alcoholism		GERD/Acid Reflux	
Anemia		Glaucoma	
Anxiety		Hay Fever (Allergies)	
Arthritis (Osteoarthritis, Rheumatoid)		Headaches/Migraines	
Asthma/COPD		Hearing Problems	
Back Pain		Hepatitis	
Bipolar Disorder		High Blood Pressure/Hypertension	
Birth Defects		High Cholesterol	
Cancer:		Kidney Disease	
-Breast Cancer		Lupus (SLE)	
-Colon Cancer		Mitral Valve Prolapse	
-Lung Cancer		Obsessive Compulsive Disorder	
-Colon Cancer		Osteoporosis	
-Skin Cancer		Panic Attacks	
-Prostate Cancer		Polycystic Ovarian Syndrome (PCOS)	
-Other Cancer		Schizophrenia	
Colon Polyps		Skin Disease	
Dementia		Stroke/Cerebrovascular Accident	
Depression		Suicide Attempt	
Diabetes Mellitus		Thyroid Disorders	
Drug Addiction		Other	
Eating Disorder			

Immunizations: Please indicate the year of your last immunization (estimate if necessary):

_____ Tetanus (TDaP, dTap)

_____ Pneumonia

_____ Shingles (Zostavax)

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Personal Medical History:

Disease	Year	Disease	Year	Disease	Year
Acid Reflux (Heartburn)		Depression/Suicide Attempt		Neuropathy/Nerve Damage	
Attention Deficit (ADHD/ADD)		Diabetes, Circle: Type 1 Type 2		Osteopenia/Osteoporosis	
Alcoholism		Eating Disorder (Bulimia/anorexia)		Pancreatitis	
Allergies (environmental)		Eczema		PCOS Polycystic Ovarian Syndrome	
Anemia		Epilepsy/Seizures		PTSD	
Anxiety/OCD		Erectile Dysfunction		Prostate Problem	
Arthritis		Fibromyalgia		Psychiatric Disorder (Other)	
Asthma		Genetic disease		Skin Problems	
Atrial Fibrillation		GERD/Acid Reflux		Sleep Apnea	
Back Pain/Injury		Glaucoma/Cataracts		Stroke/CVA	
Bipolar Disorder		Heart Disease		Thyroid Disorder	
Bleeding problem		Hepatitis		Tuberculosis	
Blood transfusion		High Blood Pressure/Hypertension		Ulcer	
Cancer – Type:		HIV/AIDS		Other	
Cholesterol problems		Irritable Bowel Syndrome			
Chronic Pain		Kidney Disease		**Last Colonoscopy Date**	
Coagulation (Bleeding disorder)		Lupus (SLE)		**Last Mammogram Date**	
Colon issues (polyps, colitis, etc.)		Migraine Headaches		**Last PAP Date**	
Dementia					

Women Only:

No. of Pregnancies: _____ No. of Miscarriages: _____
No. of Deliveries: _____ No. of Abortions: _____

First Day of Last Menstrual Period: _____ Last PAP Smear: _____
Frequency of Periods: _____ Any abnormal PAPs: _____
Length of Periods: _____

Social History:

Ethnic Background: ☐ White/Caucasian, Non-Hispanic ☐ Black, Non-Hispanic ☐ Hispanic/Latino
☐ Native American ☐ Native Hawaiian ☐ Asian ☐ Other

Marital Status: ☐ Single ☐ Married/Living with Partner ☐ Separated ☐ Divorced ☐ Widowed

No. of Children: _____

Sexual Activity: Are you sexually active? ☐ Yes ☐ No Preferred Partners: ☐ Male ☐ Female
Contraceptive: ☐ Pill/Patch/Nuvaring ☐ Barrier Method ☐ IUD ☐ Implant ☐ Sterilization
Condom Use: ☐ Yes ☐ No
Have you ever had a sexually transmitted infection? _____

Tobacco Use: ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker: _____ packs per day

Tobacco Type: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew/Snuff

Alcohol Use: ☐ Yes ☐ No Type: ☐ Beer ☐ Wine ☐ Hard Liquor
How much? _____ per (circle: Day, Week, Month)

Illicit Drug Use: ☐ Yes ☐ No

Surgical History:

Surgery Name	Date	Surgery Name	Date