



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)



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