

Confidential Health
History (Adult)

Alamo City Medical Group

- Family Practice
- Urgent Care
- Workers Comp.

Updated 10/15/09

Name	Age	Birth Date	Today's Date
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of last physical examination		Referring Physician/Person

PAST HISTORY Check (✓) symptoms you currently have or have had in the past.

<input type="checkbox"/> Abnormal PAP	<input type="checkbox"/> Depression	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Alcohol Problem	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Reflux
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes - Insulin Dependent	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> HIV	<input type="checkbox"/> Seizures
<input type="checkbox"/> Asthma/Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Sexual Disease - VD
<input type="checkbox"/> Back Trouble	<input type="checkbox"/> Essential Hypertension (High Blood Pressure)	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Bowel Trouble	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Cancer Type:	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Malignant Neoplasm (Cancer) Type:	<input type="checkbox"/> Stroke
<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Myocardial Infarction (Heart Attack)	<input type="checkbox"/> Tuberculosis
Last Mammogram date / /	Last PAP Smear date / /	Last Prostate Exam date / /	

DIET TYPE:

Have you ever had a blood transfusion? No Yes If yes, please give approximate dates.

SURGERIES and MAJOR INJURIES (Please check any surgery you have had)

<input type="checkbox"/> Appendix	<input type="checkbox"/> Breast	<input type="checkbox"/> Uterus	<input type="checkbox"/> Other (list)	Year	Hospital
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> D & C	<input type="checkbox"/> Prostate			
<input type="checkbox"/> Hernia	<input type="checkbox"/> Ovaries	<input type="checkbox"/> Testes			
<input type="checkbox"/> Tonsils	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Vasectomy			

ALLERGIES (Please List) **TYPE OF REACTION**

FAMILY HISTORY Fill in health information about your blood relatives below.

Relation	Age at Death	Living & Well	Cause of Death / Illness	Relation	Age at Death	Living & Well	Cause of Death / Illness
Father				Brother			
Grandmother							
Grandfather							
Mother				Sister			
Grandmother							
Grandfather							

Check (✓) if your blood relatives have had any of the following.

Disease	Relationship to you	Disease	Relationship to you
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Malignant Neoplasm	
<input type="checkbox"/> Other Cardiovascular (Hypertension)		Type:	
<input type="checkbox"/> Respiratory		<input type="checkbox"/> Other	
<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Other	
<input type="checkbox"/> Neurological Disorder		<input type="checkbox"/> Other	

SOCIAL HISTORY

Marital Status (circle one) Single Married Widowed Divorced Partnered

Do you / did you ever drink alcohol?
 No Yes What type? How much per week? For how many years? When did you stop?

Do you / did you ever use tobacco?
 No Yes What type? How much per day? For how many years? When did you stop?

Do you / did you ever use any other recreational drugs?
 No Yes What type? How much per day? When did you start? When did you stop?

GYNECOLOGIC HISTORY

Number of Pregnancies:	Complications of any:	Birth Control Pills <input type="checkbox"/> No <input type="checkbox"/> Yes
Number of Miscarriages:		Are you Pregnant <input type="checkbox"/> No <input type="checkbox"/> Yes
Date of last period:		Age when you first started having periods:

Is your menstrual cycle (circle one) Normal Irregular Heavy Light Have you reached Menopause No Yes Age: