Silver Sage Center for Family Medicine

Andrew Pasternak, M.D., Teresa Angermann, D.O., Jason Crawford M.D., Melanie Perl A.P.R.N

Adult Health History

Date: ___________

Name: ____ D.O.B. ______________ Gender M F

Occupation: ________________ Highest level of education __________Birth place _____________________

Marital Status single/married/widowed/divorced/separated

Children (names/ages) ____

__NO KNOWN ALLERGIES

Allergies	Reaction

Medications and dosages:

Medical History

Do you currently have or have had in the past any of the following (check all that apply):

O Allergies (seasonal)	**O** Diabetes	**O** Anemia	**O** Cirrhosis	**O** Depression
O Asthma	**O** GERD (reflux)	**O** Heart attack	**O** Hepatitis	**O** Anxiety
O Benign prostatic hypertrophy	**O** Tension headaches	**O** Obesity	**O** Sexually transmitted disease	**O** Colon Cancer
O Gallstones	**O** Migraine headaches	**O** Osteoarthritis	**O** HIV	**O** Breast cancer
O Congestive heart failure	**O** Hyperlipidemia (high cholesterol)	**O** Osteoporosis	**O** Urinary incontinence	**O** Skin cancer
O COPD (emphysema)	**O** Hypertension (high blood pressures)	**O** Peptic ulcer disease	**O** Chronic sinusitis	**O** Prostate cancer
O Coronary artery disease	**O** Hypothyroidism	**O** Blood clots	**O** Dementia	**O** Lung cancer
O Other ____________				

Surgical History

Have you had any of the following surgeries? If so, what year?

O Appendix__________	**O** Heart___________	**O** Hernia____________	**O** Stomach___________	**O** Breast augmentation/ reconstruction/biopsy
O Arthroscopy________	**O** Cataract___________	**O** Joint replacement___	**O** Brain_____________	**O** Thyroid___________
O Biopsy____________	**O** Gallbladder________	**O** Sinus_____________	**O** Hemorrhoids_______	**O** Hysterectony_______
O Other_____________				

Social History

Have you ever smoked? Y N	Do you currently smoke? Y N	Are you interest in quitting? Y N
How much do you smoke? ______pack(s) a day for ______ years	How much alcohol do you drink in a week? __________________________	Do you use illicit drugs? Y N What kind? ______________________

Do you exercise? Y N If so, how often ___________ What kind of exercise? __________________________

Do you have a living will? Y N Do you have a medical power of attorney? Y N

Do you want information on advanced directives? Y N

Family History

Disease	Father	Mother	Sibling	Grandparents	Children
Diabetes					
Cancer (if so what type)					
Heart disease/attack					
High blood pressure					
Stroke					
Thyroid disease					
Asthma					
Migraine headache					
Obesity					
Anemia					
Bleeding tendency					
Problem with anesthesia					
Depression/anxiety					
Bipolar					
Kidney disease					
Substance abuse					

Immunizations

Last Tetanus _____________	Last Influenza____________	Last Pneumovax__________	Hepatitis B ______________

OB/GYN History

Date of last menstrual period _______	Regular cycles? Y N	Pain/heavy bleeding with periods? Y N
Date of last pap smear _____________	Need for birth control? Y N	Using birth control? Y N
Number of pregnancies ____________	Number of births ___________________	Number of abortions ______________
Number of miscarriages ____________	Age of first menstrual period _______	Age of menopause ________________