Silver Sage Center for Family Medicine
Adult Health History

Date_____

Name_____ DOB_____ Gender M F

Occupation_____ Highest level of education_____ Birthplace_____

Marital Status single/ married/ widowed/ divorced/ separated

Children (names/ages) _____

Allergies	Reaction

☐ **No known allergies**

Medications and dosages _____
_____
_____

Medical History

Do you currently have or have had in the past (check all that apply)

☐ Allergies (seasonal)	☐ Diabetes	☐ Iron deficiency anemia	☐ Cirrhosis	☐ Depression
☐ Asthma	☐ GERD (reflux)	☐ Myocardial infarction (heart attack)	☐ Hepatitis	☐ Anxiety
☐ Benign prostatic hypertrophy	☐ Tension headaches	☐ Obesity	☐ Sexually transmitted disease	☐ Colon cancer
☐ Gallstones	☐ Migraine headaches	☐ Osteoarthritis	☐ HIV	☐ Breast cancer
☐ Congestive heart failure	☐ Hyperlipidemia (high cholesterol)	☐ Osteoporosis	☐ Urinary incontinence	☐ Skin cancer
☐ COPD (emphysema)	☐ Hypertension (high blood pressure)	☐ Peptic ulcer disease	☐ Chronic sinusitis	☐ Prostate cancer
☐ Coronary artery disease	☐ Hypothyroidism	☐ Blood clots	☐ Dementia	☐ Lung cancer
☐ Other_____				

Surgical History

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

☐ Appendix_____	☐ Heart_____	☐ Hernia_____	☐ Stomach_____	☐ Breast augmentation /reconstruction/biopsy
☐ Arthoscopy_____	☐ Cataract_____	☐ Joint replacement_____	☐ Hernia_____	☐ Thyroid_____
☐ Biopsy_____	☐ Gallbladder_____	☐ Sinus _____	☐Hemorroids____	☐ Hysterectomy_____
☐ Other_____				

Social History

Have you ever smoked? Y N	Do you currently smoke? Y N	Are you interested in quitting? Y N
How much do you smoke _____ pack/day	How much alcohol do you drink 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 advance directives? Y N

Family History

History of disease	Father	Mother	Sibling	Grandparents	Children
Diabetes					
Cancer (if so, what type)					
Heart Disease					
High Blood Pressure					
Stroke					
Thyroid disease					
Asthma					
Migraine Headache					
Obesity					
Anemia					
Bleeding tendency					
Problems with anesthesia					
Depression/anxiety					
Bipolar disorder					

Immunizations
Last Tetanus_____ Last Influenza_____ Last Pneumovax_____ Hepatitis B_____

OB/GYN History		
Date of Last Menst Period_____	Regular cycles? Y N	Pain/Heavy bleeding with periods? Y N_
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_____