

ADULT MEDICAL HISTORY FORM

		D	ate of Birth:	
CAL CENTER, P.A.	Reason for today's office Visit: _			
ormation on this	s form will assist your physician to	better understand your	medical concerns and cor	nditi
В	est estimates are acceptable if you	cannot recall specific da	ites. Thank you.	
ersonal Medica Proximate date of illr	I l History: Please indicate whether yo	u have had any of the follov	ving medical problems (with	
Heart Disease: specify		Cancer (malignancy) specify:		
	gh Blood Pressure)	Depression/anxiety		
Diabetes High Cholesterol		otner:		
PAD				
☐ Stroke (year :)			
Osteoporosis				
☐ Thyroid Problems	s: specify			
	Medication	Dose	Times per Day	
			_	
narmacy Name	:	Phone:		
lergies: Please p	rovide prescription and non-prescription r	medicines, vitamins, & birth	control pills.	
<u> </u>	· · · · · · · · · · · · · · · · · · ·		action	
	Allergy	Ke	action	

<u>Surgical History:</u> Please list all prior surgeries and dates.

	Surge	ery	Date	
C: - I O	D			
Social &	Preventative History:			
	rently smoke or chew tobace many packs per day?	co? Yes No	☐ Former Smoker	
	rently drink alcohol, beer, or drinks per day?	wine? Yes No		
Do you cur	rently drink caffeine?	□Yes □ No		
Family H	listory:			
	<u>Living</u>	Age (or age at death)	<u>List Serious Illnesses</u>	
Mother	☐ Yes ☐ No			
Father	☐ Yes ☐ No			
Sisters	☐ Yes ☐ No			
Sisters	Yes No			
Sisters	☐ Yes ☐ No			
Brothers	∐Yes ∐No			
Brothers	∐Yes ∐No			
Brothers	∟Yes ∟No			
Women	History:			
Date of las	t menstrual period:		Date of last Pap smear:	
Date of last mammogram:			Are you pregnant?	
Number of	children			
				_
By signing	below, I hereby certify to th	e best of my knowledge	e that the information I have provided is comp	olete, true,
and accurd	ite.			
Patient/Le	gal Guardian Signature:		Date:	