

North Texas Medical-Surgical Clinic

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Denton, Texas 76201
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Family Medicine
Internal Medicine
Sports Medicine

Adult Health History Form

Name: _____ Date of

Birth: _____

Age: _____ Social Security #: _____

Personal Medical History:

Please list any chronic medical problems that you have, with dates of when they were diagnosed:

Please list any surgeries that you have had, and dates of those surgeries:

Medications: Please list any prescription and non-prescription medications that you taking (including vitamins, herbal/alternative treatments, birth control pills, etc.)

Medication	Dose (mg)	How many times per day
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies or Reactions to Medications: Please list medication and reaction:

Immunizations/Vaccines: Have you had any of these vaccines or immunizations?

Pneumonia	Y	N	When?	Flu	Y	N	When?
Tetanus	Y	N	When?	Hepatitis	Y	N	When?

Women's Health History

How many pregnancies have you had? _____ How many deliveries? _____

Age at onset of periods _____ Age at menopause _____ N/A

Adult Health History Form

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Which of the following health maintenance screening tests have you had?

- Complete Physical Y N If yes, when and where?
_____ Were there any abnormalities? Y N
- Pap Smear Y N If yes, when and where?
_____ Were there any abnormalities? Y N
- Mammogram Y N If yes, when and where?
_____ Were there any abnormalities? Y N
- Colonoscopy Y N If yes, when and where?
_____ Were there any abnormalities? Y N
- Prostate exam Y N If yes, when and where?
_____ Were there any abnormalities? Y N
- PSA(prostate) level Y N If yes, when and where?
_____ Were there any abnormalities? Y N
- Cholesterol level Y N If yes, when and where?
_____ Were there any abnormalities? Y N
- Eye Exam Y N If yes, when and where?
_____ Were there any abnormalities? Y N
- Dental Exam Y N If yes, when and where?
_____ Were there any abnormalities? Y N

Family Health Information:

Please circle the disease if anyone in your family has these diseases and write your relationship to that person.

Heart attack	<u>Relationship</u>	High blood pressure	<u>Relationship</u>
High cholesterol		Diabetes	Sudden
unexplained death		Stroke	
Alcohol or drug abuse		Depression	
Cancer, specify type		Other: _____	
Other: _____			

Social History:

Do you exercise regularly? Y N What kind of exercise? _____

Do you smoke? (circle and complete the answer that applies)

Never Quit ___years ago Still smoking ___packs per day

Do you use other types of tobacco? Y N If yes, what types, and how often? _____

Do you drink alcohol? Y N If yes, how many drinks per week? _____

Do you use any recreational drugs? Y N If yes, what types, and how often? _____

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Adult Health History Form

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Name: _____

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Who lives at home with you?

Name

Age

Relationship

Other Concerns:

Have you ever had any sexually transmitted diseases (STDs)? Y N

Do you wear seatbelts consistently? Y N

Is violence at home a concern for you? Y N

Have you ever been abused? Y N

Do you have a gun in your home? Y N

If you answered "yes" to any of these questions, please explain.

Is there any other important information about you that we missed?

If yes, please describe.

Signature _____ Date
