2019

Adult Health History

Name: _____ DOB: _____

Employer: _____ Highest Level of Education: _____

Reason for Visit: _____

Hospitalizations: State year followed by illness or operation (most recent first)

Past Medical and Family History

(Please check if you or any BLOOD relative has these conditions. Please name SPECIFIC relatives)

Condition	You	Relative	Condition	You	Relative
Diabetes			Psoriasis/Eczema		
Hypertension			Bowel Issues		
High Cholesterol			Kidney/Bladder Problem		
Coronary Artery Disease			Kidney Disease		
Stroke/TIA			Arthritis		
Cardiac Arrhythmia			Recent Weight Loss		
Heart Attack			Migraine Headaches		
Heart Disease			Epilepsy/Seizures		
Sleep Apnea			Head Trauma		
COPD/Emphysema			Eye Disease		
Asthma			Pulmonary Embolism		
Chronic Pain			Heartburn/Reflux		
Gout			Liver Disease/Hepatitis		

Name: _____ DOB: _____

PRIMARY CARE PHYSICIANS of Gainesville

PAST MEDICAL AND FAMILY HISTORY

(Please check if you or any BLOOD relative has these conditions. Please name SPECIFIC relatives)

Condition	You	Relative	Condition	You	Relative
Obesity			Parkinson's Disease		
Thyroid Disease			Lupus		
Insomnia			Cancer		
Depression			Type:		
Anxiety					
Osteoporosis					
Anemia					

Please list any other illness that you have been diagnosed with:

_____

_____

FAMILY HISTORY

Mother: □ Alive □ Deceased Age at Death _____ Cause of Death _____

Father: □ Alive □ Deceased Age at Death _____ Cause of Death _____

SOCIAL HISTORY

Do you drink caffeine? □ Yes □ No Tobacco Use? □ Yes □ No □Quit: _____

Tobacco: PPD: _____ Years of Use:_____

Recreational Drug Use? □ Yes □ No □Quit: _____

Alcohol use? □Yes □No □Quit: _____ Frequency:_____ Average daily: _____

Last Time You Had:

Eye Exam:_____ Colonoscopy: _____ Stool Blood Test: _____ Dental Exam:_____

Flu Vaccine: _____ Tetanus Shot: _____ Pneumonia Shot: _____ Shingles Shot: _____

Name: _____ DOB: _____

PRIMARY CARE PHYSICIANS of Gainesville

Medications

Medication	Dose & Frequency	Reason

Allergies

Medication	Reaction Type

Pharmacy: _____

Name: _____ DOB: _____

PRIMARY CARE PHYSICIANS of Gainesville

WOMEN ONLY

Date of last period: _____/_____/_____ Regular: ☐ Y ☐ N Spotting: ☐ Y ☐ N

Birth Control: ☐ Y ☐ N Name/Type: _____

Number of Pregnancies:_____ Number of Births: _____

Number of Abortions: _____ Number of Miscarriages: _____

Date of Last

Pap: _____ ☐ Normal ☐ Abnormal

Breast Exam: _____ ☐ Normal ☐ Abnormal

Mammogram: _____ ☐ Normal ☐ Abnormal

Bone Density: _____ ☐ Normal ☐ Abnormal

Additional Comments:

_____

_____