Charis Family Clinic ADOLESCENT/ADULT Medical History Information

(14 and older)

Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Sex: _____Male _____Female Hm phone_____ Cell phone _____ Work phone _____Email _____

Pharmacy Name _____ Pharmacy #(____)_____

REVIEW OF SYSTEMS (Please answer if you are having any of these symptoms CURRENTLY):

General: ☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Weakness ☐ Awakening feeling unrefreshed
Skin: ☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness ☐ Color changes ☐ Hair or nail changes
Head: ☐ Headache ☐ Head injury
Ears: ☐ Decreased hearing ☐ Ringing in ears ☐ Earache ☐ Drainage
Eyes: ☐ Visual change _____ ☐ Glasses or contacts ☐ Eye pain ☐ Redness ☐ Blurry or double vision ☐ Flashing lights
Nose: ☐ Stuffiness ☐ Discharge ☐ Itching ☐ Hay fever ☐ Nosebleeds ☐ Sinus pain
Throat/Mouth: ☐ Tooth problems ☐ Sore tongue ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush
Neck: ☐ Lumps ☐ Swollen glands ☐ Pain ☐ Stiffness
Breasts: ☐ Lumps ☐ Discharge ☐ Pain
Respiratory: ☐ Cough (dry or productive)? ☐ Sputum color _____ ☐ Coughing up blood ☐ Wheezing ☐ Shortness of breath ☐ Alcoholism
Cardiovascular: ☐ Chest pain or discomfort ☐ Chest tightness ☐ Palpitations ☐ Shortness of breath with activity ☐ Difficulty breathing lying down ☐ Swelling (edema) ☐ Sudden awakening from sleep with shortness of breath
Gastrointestinal: ☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea ☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea ☐ Vomiting
Urinary: ☐ Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine ☐ Incontinence ☐ Change in urinary flow
Genital/Reproductive: **Male--**☐ Pain with sex ☐ Hernia ☐ Penile discharge ☐ Genital sores ☐ Masses or pain ☐ Difficulty sustaining an erection
Female--☐ Pain with sex ☐ Vaginal dryness ☐ Hot flashes ☐ Vaginal discharge ☐ Vaginal itching or rash ☐ Sores
Extremities: ☐ Calf pain with walking ☐ Leg cramping
Musculoskeletal: ☐ Muscle pain ☐ Joint pain ☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints ☐ Recent trauma/injury
Neurologic: ☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness (localized/in one area only) ☐ Numbness ☐ Tingling
Hematologic: ☐ Easy bruising
Endocrine: ☐ Heat or cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst ☐ Eating much more than usual
Psychiatric: ☐ Nervousness/anxiety ☐ Depression ☐ Memory loss ☐ Stress ☐ Poor motivation ☐ Difficulty concentrating

PAST MEDICAL HISTORY

Are you allergic to any medications? _____No ____Yes: which ones (list REACTION after each)?_____
_____

Do you have any history of:

☐ Alcoholism
☐ Allergies (to _____)
☐ Anemia
☐ Anxiety
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Clot
☐Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer (type____)
☐ Cataract
☐ Chicken Pox
☐ Diabetes
☐ Depression
☐ Drug Use (type _____)
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Failure
☐ Hepatitis (type ____)
☐ Hernia
☐ High Cholesterol
☐ HIV positive
☐ Kidney Disease
☐ Kidney Infection
☐ Kidney Stone
☐ Liver Disease
☐ Migraine headaches
☐ Metabolic Disorder
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Osteoporosis
☐Peptic Ulcer
☐ Pneumonia
☐Prostate problem
☐ Reflux (GERD)
☐Rheumatic Fever
☐Scarlet Fever
☐Sexually transmitted infection (type _____)
☐Stroke
☐Suicide attempt
☐Thyroid problem
☐Tonsillitis
☐Tuberculosis
☐Tropical disease (type_____)
☐Urinary tract infection
☐Vaginal infection
☐ Other(_____

Have you had any surgeries? Please list type and approximate date:

_____

_____

Have you ever been hospitalized? __No __Yes. If yes, for what reason? _____

Have you ever had a blood transfusion? ____ If yes, approximate date _____

Have you served in the armed forces? ___ If yes, indicate type & years of service _____

List medications you currently take. Include all prescription, over-the-counter and herbal medications and the dose of each.

_____ _____

_____ _____

Check the immunizations or screening tests you've had. Please give the approximate (last) date for each.

☐ Measles _____ ☐ Colonoscopy _____

☐ Rubella _____ ☐ Mammogram _____

☐ Chicken Pox _____ ☐ Dexascan _____

☐ Tetanus (Td) _____ ☐ Other _____

☐ Tetanus with pertussis(Tdap) _____ ☐ Influenza _____

☐ Pneumonia _____ ☐ Shingles _____

☐ Meningococcal _____

GYNECOLOGICAL & PREGNANCY HISTORY (if applicable)

Age of 1st menstrual period _____

How often do you have a menstrual period? Every ___ days

Any problems with your periods?

Age at 1st intercourse?

Type of contraception used?

Number of pregnancies _____

Number of miscarriages _____

Number of terminations_____

Number of live births _____

Number of still births _____

FAMILY MEDICAL HISTORY

	Father	Mother	Child	Sibling	Grandparent	Other
Alcoholism	☐	☐	☐	☐	☐	☐
Alzheimers/Dementia	☐	☐	☐	☐	☐	☐
Asthma or Allergies	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer: type _____	☐	☐	☐	☐	☐	☐
Depression, Anxiety	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐

Please list any other conditions in your family: _____

SOCIAL HISTORY

Race (check all that apply): ☐ African-American ☐ Caucasian ☐ Native American ☐ Asian ☐ Hispanic/Latino ☐ Middle Eastern ☐ Pacific Islander ☐ Other _____Ethnic/country background:_____

Preferred Language: _____ Other Languages spoken: _____

What is your religious/faith background?_____ Do you attend services regularly?_____ Where? _____

Have you ever smoked? ___**If yes**, for how many years? ___ How much do you smoke now? _____**If you no longer smoke**, when did you stop?

Do you drink alcohol? _____ Kind of alcohol? _____ Number of alcoholic drinks/servings you consume per week? ___ Most at one time?____

Have you ever had a problem with alcohol or felt you should cut down? _____

Have you ever used illegal substances? ___No ___Yes. If yes, type _____ When was the last time you used?___

Have you ever overused prescription medications? ___No ___If yes, type _____

SOCIAL HISTORY, continued

Sexual Preference: ___Men ___Women ___Both Are you: ___Single ___Married ___Partnered ___Separated ___Divorced ___ Widowed

Do you feel safe in your current relationship? ___ No ___ Yes Do you work outside the home? ___No ___Yes: occupation_____

Exercise: Type, duration & frequency _____ Caffeine: # ___ soda ___ tea ___ coffee per day

Any occupational concerns: (stress, hazardous substances, air pollution, heavy lifting)? _____

Do you have a Health Care Directive? ____ If no, would you like to have one? _____

Date: _____ Patient Signature (or legal guardian) _____