FORNANCE PHYSICIAN SERVICES, INC.
ADULT MEDICAL HISTORY

Patient Name _____ Sex_____ Age _____ Birth Date _____

Allergies to Medications, X-Rays Dyes, or Other Substances ☐ No ☐ Yes
(If yes, please list what you are allergic to and type of reaction)

Medications: (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Past Medical History & Review of Systems
Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest pain/chest tightness
6. Shortness of Breath
7. Swollen ankles
8. Palpitations
9. Light-headedness
10. Frequent urination
11. Rheumatic Fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent Cough
16. T.B.
17. Hay Fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in Stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall Bladder Disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid Disease
33. Head or Neck radiation
34. Headache
35. Kidney Disease
36. Kidney Stones
37. Difficulty urinating
38. Arthritis
39. Low Back Problems
40. Skin Disorders
41. Blood Disorders
42. Venereal Diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol Abuse
47. Drug Abuse
48. Gout
49 Last Dental visit _____
50 Last Ophthalmologist visit _____

Gynecologic & Obstetric History

Last Pap test: _____ LMP _____ Last Mammogram _____

Age at onset of periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding: ☐ No ☐ Yes

Leakage of Urine: ☐ No ☐ Yes

Pelvic Pain: ☐ No ☐ Yes

Abnormal Discharge: ☐ No ☐ Yes

History of abnormal Pap smear: ☐ No ☐ Yes Name of Gynecologist: _____

Please List and Supply the date of:

IMMUNIZATIONS	OPERATIONS	OTHER HOSPITALIZATIONS
☐ Hepatitis B _____		
☐ Pneumovax _____		
☐ Flu _____		
☐ Tetanus _____		

Family History

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Which family members?	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Osteoporosis		
Other		

Prevention

Do you wear seat belts? ☐ No ☐ Yes

Do you wear a bike helmet? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes

Do you drink alcoholic beverages? ☐ No ☐ Yes

Do you drink coffee/tea? ☐ No ☐ Yes

Is there a gun in your home? ☐ No ☐ Yes

Is the gun unloaded? ☐ N/A ☐ No ☐ Yes

Do you use drugs? ☐ No ☐ Yes

Have you ever engaged in any activity which has put you at risk of getting AIDS? ☐ No ☐ Yes

Do you wish to be tested for AIDS? ☐ No ☐ Yes

Occupation _____

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? ☐ No ☐ Yes

Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes

Do you feel afraid of your partner? ☐ No ☐ Yes

Do you have a "living will"? ☐ No ☐ Yes

Do you have a donor card? ☐ No ☐ Yes

Method of birth control _____

Physician Use Only

P.A.

C.R.N.P.

M.D.

D.O.

Date _____ Physician Signature _____