ADULT'S PATIENT HISTORY FORM

Please fill out the following on your family history. Use ( ) to indicate deceased.

Relatives	Age or (Age at Death)	Health Problem or (Cause of Death)
Father		
Mother		
Sister(s)		
Brother(s)		
Grandparents		
Son(s)		
Daughter(s)		
Other Family History:		

Marital status: _____

Education: _____

Occupation: _____

Are your vaccines up to date? ..... Yes ..... No ..... Unknown
(Tetanus, Hepatitis, Pneumonia shots)

Who do you live with: _____

Do you have a living will? ..... Yes ..... No

Are you an organ donor? ..... Yes ..... No

Blood transfusion prior to 1992? ..... Yes ..... No

Do you?

Drink coffee, tea or caffeinated beverages ..... Yes ..... No
If yes, how much per day: _____

Do you eat a special diet ..... Yes ..... No
If yes, what kind: _____

Do you have firearms in the home ..... Yes ..... No
If yes, stored how: _____

Use smokeless tobacco/snuff ..... Yes ..... No
If yes, how much per day: _____

Smoke ..... Yes ..... No ..... How much: _____
Use recreational drugs ..... Yes ..... No

Drink alcohol .. Yes ..... No ..... How much: _____
Wear a seatbelt ..... Yes ..... No

Exercise ..... Yes ..... No ..... How much: _____
Are you sexually active ..... Yes ..... No

What are your hobbies? _____

Please list past medical information below including diagnosis, hospitalizations, surgeries, and procedures (diabetes, hypertension, stress test, heart cath., colonoscopy)

Date	Reason

List all medications currently taking (including vitamins & herbs): _____

_____

Any known allergies? _____

List any current symptoms or concerns you would like to discuss with with doctor: _____

_____

_____
Signature of Patient/Guardian

_____
Date

Patient Name: _____

Patient ID: _____