Adult History form

Patient Name **DOB** **Date----------**

Past Medical History

Diabetes	*Yes*	*No*	
Hypertension (High Blood Pressure)	*Yes*	*No*	
Stroke	*Yes*	*No*	
Heart Disease:	*Yes*	*No*	*if so, what type?*
High Cholesterol:	*Yes*	*No*	
Liver Disease/Hepatitis:	*Yes*	*No*	
Osteoporosis:	*Yes*	*No*	
GI Disease:	*Yes*	*No*	
Cancer:	*Yes*	*No*	*If so, what type?* ____ _____
Depression:	*Yes*	*No*	
Eating Disorders:	*Yes*	*No*	

Other medical problems in the past:

Past Surgery:

Reproductive History:

Age of first menstrual period: _____ Cycles Regular: _____
Any OB/GYN Surgeries: _____ Prior Pregnancies: _____
How Many were live births? _____ Miscarriage:
Are you on hormone therapy: ___ _____
Any History of PCOS (polycystic ovarian syndrome)? Yes / No

Family Medical History:

Diabetes---------- Parathyroid disease----------
Thyroid Disorder----------High cholesterol----------
Thyroid cancer----------Pituitary disorder----------
High Blood Pressure ----------Heart disease----------
Other disorders----------

Social History: Married /Single/ Divorced/ Separated/ Widowed
Occupation: _____
Do You Smoke? Yes No Current Smoker or Ex-Smoker?_____
If so how much?_____ How long:_____ _____
Do you use Alcohol? Yes No How Often?_____ _____
Do you use Drugs? Yes No

Patient Name **DOB** **Date**

Immunizations:
Pneumonia Vaccine Flu Vaccine

Mammogram: **Colonoscopy**

Bone Density **Neck Ultrasound**

Current Medications: Please include Over the Counter Meds and Vitamins
Name and Dosage

Allergies:----------

REVIEW OF SYSTEMS:
Review of Systems (Please circle all that apply)

CONSTITUTIONAL: weakness, fatigue, weight loss, weight gain, fever, chills, sweats, insomnia, snoring
HEAD: headache
EYES: visual changes, defects, blurring of vision
NOSE: nose bleeds, discharge, lack of sense of smell
MOUTH & THROAT: dental disease, hoarseness, sore throat, trouble swallowing
PULMONARY: cough, wheezing, shortness of breath
CARDIOVASCULAR: chest pain, heart racing, sudden collapse or loss of consciousness, swelling of feet, irregular heart rate
GASTROINTESTINAL: nausea, vomiting, diarrhea, constipation, changes in bowel habits, abdominal pain, black stools or blood in stools, yellowness of eyes, appetite changes, early feeling of fullness on eating
MUSCULOSKELETAL: back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness

Patient Name **DOB** **Date**

SKIN: rash, itching, dryness, changing mole size or other suspicious lesions
NEUROLOGICAL: weakness, tingling or numbness, seizures, tremors, memory problems or gait problems
HEMATOLOGIC: easy bruising, bleeding, joint swelling
PSYCHIATRIC: depression, anxiety, memory loss
ENDOCRINE REVIEW OF SYSTEMS :(**Please circle all that apply)**
PITUITARY/HYPOTHALAMUS: headaches, visual defects, increased thirst or urination, milky discharge from breast, painful breast swelling, increased head/hand or shoe size, history of pituitary tumor, peptic ulcer disease, family history of kidney stones, family history of multiple endocrine tumors
THYROID: fatigue, anxiety, nervousness, tremor, heat intolerance, cold intolerance, lethargic, dry skin, constipation, heart racing, weight loss, weight gain, sweating, hair loss, neck pain, history of head or neck radiation, difficulty swallowing or breathing, family history of thyroid cancer
PARATHYROID: increased thirst and urination, history of kidney stones, use of antacids, calcium supplements, bone pain, muscle aches, loss of height, history of fractures
ADRENAL: darkening of skin/gums, salt craving, skin stretch marks, easy bruising, diarrhea, vomiting, weight loss, change in facial or physical appearance, excess hair growth over face/chin/chest/or abdomen, weight gain, difficulty raising arms overhead, difficulty getting up from a seated position
GENITOURINARY: irregular menstrual cycles, hot flashes, impotence, decreased libido, erectile dysfunction, decreased hair growth
BONE: height loss over the years, history of fracture, family history of osteoporosis

Symptoms reviewed today**: Mandana Ahmadian, MD** Date: