Randolph Health Medical Group

Adult History-1

Patient's Name _____ Male / Female Date of Birth _____

**CURRENT MEDICATIONS** (Name of prescription and over the counter medications & dosage)

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

**Do you take any:**

□ Herbal Products
□ Vitamins
□ Minerals
□ Aspirin

**ALLERGIES & REACTIONS** □ No known Allergies **LOCAL PHARMACY:**_____

Drugs _____

Food _____ Other _____

**PAST MEDICAL & FAMILY HISTORY** (Please check if you or your family members have had any of the following diseases)

| | Self | Father | Mother | Grandparent (Maternal) | Grandparent (Paternal) | Brother | Sister |
|---|---|---|---|---|---|---|---|
| Diabetes | □ | □ | □ | □ | □ | □ | □ |
| High Blood Pressure | □ | □ | □ | □ | □ | □ | □ |
| High Cholesterol | □ | □ | □ | □ | □ | □ | □ |
| Heart Attack | □ | □ | □ | □ | □ | □ | □ |
| Heart Disease | □ | □ | □ | □ | □ | □ | □ |
| Stroke | □ | □ | □ | □ | □ | □ | □ |
| Asthma/Emphysema | □ | □ | □ | □ | □ | □ | □ |
| Breast Cancer | □ | □ | □ | □ | □ | □ | □ |
| Colon Cancer | □ | □ | □ | □ | □ | □ | □ |
| Prostate Cancer | □ | □ | □ | □ | □ | □ | □ |
| Other Cancer _____ | □ | □ | □ | □ | □ | □ | □ |
| Sickle Cell | □ | □ | □ | □ | □ | □ | □ |
| Tuberculosis | □ | □ | □ | □ | □ | □ | □ |
| Kidney/Bladder Problems | □ | □ | □ | □ | □ | □ | □ |
| Thyroid Disease | □ | □ | □ | □ | □ | □ | □ |
| Hepatitis or Jaundice | □ | □ | □ | □ | □ | □ | □ |
| Anemia | □ | □ | □ | □ | □ | □ | □ |
| Arthritis | □ | □ | □ | □ | □ | □ | □ |
| Positive HIV/AIDS | □ | □ | □ | □ | □ | □ | □ |
| Seizure Disorder | □ | □ | □ | □ | □ | □ | □ |
| Other Illness _____ | □ | □ | □ | □ | □ | □ | □ |

**PAST SURGERIES** (Please list all past surgeries and the year performed)

□ Appendix _____ year □ Gallbladder _____ year □ Thyroid _____ year □ Hysterectomy _____ year

□ Hernia _____ year □ Heart _____ year □ Lung _____ year □ Tonsillectomy _____ year

Other _____

**RECENT HOSPITALIZATIONS** (Other than above surgeries or child birth)

| Year | Reason | Year | Reason |
|---|---|---|---|
| | | | |
| | | | |

Patient Name _____ Patient DOB _____



**HEALTH MAINTENANCE**

Men Do you do self-testicular exams? □ Yes □ No Date of last PSA _____

Women Date of last menstrual cycle _____ Age of menopause _____

Date of last pap smear _____ Have you ever had an abnormal pap smear? □ Yes □ No

Pregnancies: Total # _____ Deliveries _____ Miscarriages _____

Date of last mammogram _____ Have you ever had a breast lump? □ Yes □ No

Do you do self breast exams? □ Yes □ No

Date of last Bone Density test _____

All *(Year of last)* Colonoscopy (If over 50) _____

**SOCIAL HISTORY**

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed Number of Children: _____

Employment: □ Full-time □ Part-time □ Disabled □ Retired □ Unemployed

Occupation _____

How often do you exercise: □ None □ 1-2 days/week □ 3-4 days/week □ 5+ days/week

Caffeinated Beverages: Cups/glasses per day_____

**TOBACCO & ALCOHOL HISTORY**

Tobacco:

Do you use now? □ Yes □ No Type _____ Would you like to quit? □ Yes □ No

Have you used in the past? □ Yes □ No How many years did you use? _____ When did you quit? _____

Alcohol:

How much alcohol do you drink? □ None □ Rarely □ 1-7 drinks/week □ 8-14 drinks/week □ more than 14/week

Have you had a problem with alcohol in the past? □ Yes □ No

Recreational Drugs:

Do you currently use recreational drugs? □ Yes □ No If so, type: _____

**PERSONAL SAFETY**

How often do you wear seatbelts? □ Always □ Often □ Occasionally □ Never

Do you have firearms in your home? □ Yes □ No If yes, are they kept locked up? □ Yes □ No

Have you participated in any high risk behaviors that could put you at risk for HIV/AIDS such as: IV drug use, multiple sex partners or same sex partners? □ Yes □ No

**VACCINATIONS/SKIN TEST** (Please enter information about vaccinations/skin tests you have received)

Tetanus Vaccine _____ (year)

Flu Vaccine _____ (year)

Pneumonia Vaccine _____ (year)

TB Skin Test _____ (year)
Ever had positive TB Skin Test? □ Yes □ No

Hepatitis B Vaccine □ Yes □ No

Shingles Vaccine □ Yes □ No

HPV Vaccine □ Yes □ No
*(Genital warts & Cervical Cancer vaccine)*

Hepatitis A Vaccine □ Yes □ No

**CONSTITUTIONAL**

How do you feel in general? _____

**IF YOU HAVE A LIVING WILL OR HEALTHCARE POWER OF ATTORNEY, PLEASE PROVIDE US WITH A COPY.**