FAMILY FIRST
WOMEN & CHILDREN'S HEALTHCARE
MEDICAL AESTHETICS

Adult Patient Medical History Form

Name: _____ Date: _____

Gender: _____ Date of Birth: _____ Age:_____

What name would you like to be called? _____

How were you referred to Family First? _____

Please state brief reason for visit: _____

Marital Status: _____ Occupation: _____

Children: Yes or No How many: _____ Are they healthy?_____

Do you exercise: Yes or No If yes, what type and how often? _____

How is your diet? _____

Do/did you smoke tobacco? Yes or No	If yes, how many packs per day?_____
	If yes, how long have you smoked?_____
	If you have quit, how long ago?_____
Any exposure to second-hand smoke? Yes or No	If yes, who smokes? _____
Do/did you dip or chew tobacco? Yes or No	If yes, how much? _____
	If you have quit, how long ago? _____
Do/did you use alcohol? Yes or No	If yes, how often and how much do you drink?_____
	If you have quit, how long ago?_____
Do/did you use drugs or other substances? Yes or No	If yes, what type and how much?_____
Do you drink caffeine? Yes or No	If yes, what type and how much? _____
Are you sexually active? Yes or No	If yes, with men, women, or both?_____

OTHER HEALTH CARE PROVIDERS:

Do you see a dentist? Yes or No Last visit date: _____

Do you see an eye doctor? Yes or No Last visit date: _____

Do you see any other physicians or other health providers? Yes or No (If yes, please provide details)

Name: _____ Date of Last Visit: _____
Reason: _____

Name: _____ Date of Last Visit: _____
Reason: _____

HEALTH MAINTENANCE:

Have you had any of the following? If so, please tell approximate date and outcome:

Cholesterol Screening: _____ Stool Occult Blood Test: _____

Colonoscopy: _____ Bone Density Test: _____

Men only: Prostate Exam: _____ PSA: _____

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MEDICAL HISTORY

CURRENT DISEASES (e.g. high blood pressure, diabetes, asthma, high cholesterol, thyroid disease, etc.):

Disease	First Diagnosed (Month/Year)	Treated By (Specialist's Name)

PAST DISEASES OR SERIOUS ILLNESSES:

Disease/Illness	Date Resolved (Month/Year)	Treated By (Specialist's Name)

SURGERIES:

Surgery	Reason for the Surgery	Date of Surgery (month/year)

ALLERGIES OR ADVERSE DRUG REACTIONS?

Medication Name	Type of Reaction	When

MEDICATIONS:

Name	Strength and Dose	How often taken

NON-PRESCRIPTION: (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, supplements, etc.)

Name	Strength and Dose	How often taken

HERBAL PREPARATIONS or HOMEOPATHIC REMEDIES:

Name	Strength and Dose	How often taken

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FAMILY HISTORY:
Have any of your immediate family members had any of the following conditions?

Illness/Condition	Yes	No	Relationship to Patient	Illness/Condition	Yes	No	Relationship to Patient
Cancer				Thyroid disease			
Heart disease/heart attack				Depression/anxiety			
Stroke				Mental illness			
High blood pressure				Autoimmune disease			
High cholesterol				Other: (please list)			
Diabetes							
Sudden death before age 60?							

ADULT IMMUNIZATION HISTORY: (received at age 18 or older)

Pneumovax (Pneumococcal) No_____ Yes_____ Date: _____
Tetanus/Pertussis (DT or TDaP) No_____ Yes_____ Date: _____
Influenza No_____ Yes_____ Date: _____
Zostavax (Shingles) No_____ Yes_____ Date:_____
Gardasil (HPV) No_____ Yes_____ Date:_____
Menactra (Meningitis) No_____ Yes_____ Date:_____
Hepatitis B No_____ Yes_____ Date:_____
Hepatitis A No_____ Yes_____ Date:_____
Other_____
Did you receive childhood immunizations? **YES or NO**

REVIEW OF SYSTEMS (Symptoms within the last week):

General	Yes	No	If yes, explain and give date symptoms first started
Fever or Chills			
Sweats			
Weight Change			
Excessive Fatigue			
Psychological			
Anxiety			
Depression			
Attention Deficit Disorder			
Other			
Neurological			
Memory Changes			
Dizziness/Fainting			
Blurred Vision			
Numbness/Tingling			
Headache			
Head & Neck			
Seasonal Allergies			
Sinus Congestion			
Nose Bleeds			
Problems Swallowing			
Lesions in Mouth			
Sore Throat			
Hearing Loss			
Vision Changes			

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REVIEW OF SYSTEMS continued			
Cardiovascular			
Leg Pain or Swelling			
Palpitations			
Chest Pain			
High Blood Pressure			
Abnormal EKG			
Respiratory			
Wheezing			
Shortness of Breath			
Cough			
Asthma			
Emphysema/COPD			
Bloody Phlegm			
Sleep Apnea			
Breast			
Lumps			
Skin Changes			
Pain			
Nipple Discharge			
Gastrointestinal			
Constipation			
Nausea or Vomiting			
Reflux or Heartburn			
Change in Appetite			
Abdominal Pain			
Diarrhea			
Bloody or Black Stools			
Genitourinary			
Burning with Urination			
Blood in Urine			
Unable to Control Bladder			
Frequent Urination			
Recurrent Infections			
Musculoskeletal			
Swelling			
Joint or Back Pain			
Arthritis			
Skin			
Open Sore			
Changes in Moles			
Rashes			
Endocrine			
Cold Intolerance			
Hot Flashes			
Diabetes/Elevated Blood Sugar			
Thyroid Abnormalities			
Other: fill in blank			

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FEMALES ONLY

Age Periods Began: _____ First Day of Last Menstrual Period :_____

Current Menstrual Cycles:
How Often: _____ How Many Days: _____ Flow: (circle) Light Moderate Heavy
Pain with Periods: Yes or No

Menopausal Symptoms: Yes or No Which ones? (circle all that apply) Hot Flashes Night Sweats Problems Sleeping

Date of Last Pap: _____ Results: _____

Have you ever had an abnormal pap smear? Yes or No If yes, what type of abnormality? _____
Treatment: _____ Date (Month/Year): _____

Have you ever been treated for a sexually transmitted disease? (circle all that apply)
Syphillis Gonorrhea Chlamydia Herpes Genital Warts Other _____

Date of Last Mammogram: _____ Results:_____

Pregnancies
Live Births:

Date	Type of Delivery	Anesthesia	Length of Pregnancy	Infant Weight	Complications

Children's Ages: _____

Other Pregnancies:

Date	Length of Pregnancy	Complications/Outcome

Family Planning:
What type of contraception, if any, are you using? (Circle all that apply)
Birth Control Pills (Name) _____ Depo-Provera IUD (date inserted) _____
Diaphragm Condoms Tubal Ligation (date) _____ Vasectomy Other_____ None

Breastfeeding:
Are you currently breastfeeding? Yes or No
Have you breastfed in the past? Yes or No