

NORTH RALEIGH FAMILY MEDICINE

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ADULT MEDICAL HISTORY

Patient Name: _____ DOB: _____ Today's Date: _____

What is your reason for seeing your provider today? _____

Past Medical History

Conditions

Dates

Allergies

Hospitalizations

Present Medications

Surgeries

Last Tetanus: _____

Social History

Married Single Significant other

Children No Yes (ages): _____

Occupation: _____ Tobacco: No Yes (how much): _____

Alcohol: No Yes (how much): _____ Caffeine: No Yes (how much): _____

Recreational Drugs: No Yes (what): _____

Sleep hours per night: _____ Exercise: No Yes (how much): _____

Hobbies: _____

FAMILY HISTORY Fill in health information about your family				
Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Have any of your immediate relatives ever had the following? (check)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy or seizures
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Emotional disorders
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Neurological disorders
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Autoimmune disease
<input type="checkbox"/> Hay fever / Asthma / Allergies	

HAVE YOU EVER HAD OR DO YOU CURRENTLY SUFFER FROM? (Check)

<input type="checkbox"/> Alcohol / drug abuse	<input type="checkbox"/> Emotional problems	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy / seizures	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Appetite problems	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Muscle / joint problems	<input type="checkbox"/> Ulcer Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Neurological problems	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Arthritis / gout	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nose / Mouth / Face problems	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Fever / chills	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Weight Lose (unexpl)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Respiratory problems	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Constipation-significant	<input type="checkbox"/> Gynecologic problems	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> CHEST PAIN
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Headaches (severe)	<input type="checkbox"/> Sexual Dysfunction	
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Skin Disorders	
<input type="checkbox"/> Ear problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sleep Disorders	