Harvard Vanguard Medical Associates

Adult Medical History Form

Please complete All **3** PAGES

_____
Name

Your answers on this form will help your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you**!

PRESENT HEALTH CONCERNS: _____

_____

_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose	Times per day

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

____Congenital Heart disease:
specify type
_____
____Myocardial Infarction (Heart attack)
____Hypertension (High blood pressure)
____Diabetes
____High cholesterol____
____Stroke ____
____Thyroid problem
*specify type*_____

____Coagulation (bleeding/clotting) disorder
____Cancer (Malignancy)
*specify type*_____
____Depression/suicide attempt
____Alcoholism
____If you have ever had a blood transfusion, please specify date
_____Abnormal Pap smear

Other problems
_____
_____
_____

When was your last Tetanus shot?
_____

SURGICAL HISTORY (Please list all prior operations and dates)**:**

Operation	Date

Operation	Date

WOMEN'S GYNECOLOGIC HISTORY:

For Women: # pregnancies:____ # deliveries:____ # abortions: ____ # miscarriages: _____
1st day, most recent period: _____ Age at 1st period:____ Frequency of periods:_____ Length of each: _____
Do you have any concerns about your periods? □ No □ Yes: _____
Do you have any concerns about menopause? □ No □ Yes: _____

FAMILY HISTORY:

Please indicate with a check (√) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, skin (except melanoma)							
Cancer, Ovary							
Cancer, Prostate							
Cancer (not noted)							
Depression							
Diabetes, Type 1 (childhood onset)							
Diabetes, Type 2 (adult onset)							
Eczema							
Epilepsy(seizures)							

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Genetic diseases							
Glaucoma							
Hay fever (Allergic Rhinitis)							
Hearing problems							
Heart Attack (Coronary Artery Disease)							
High Blood Pressure (Hypertension)							
High cholesterol (Hyperlipidemia)							
Kidney diseases							
Lupus (Systemic Lupus Erythematosis)							
Mental retardation							
Migraine headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke							
Thyroid disorders							
Tuberculosis							
Other:							

SOCIAL HISTORY

SUBSTANCES
Tobacco Use
Cigarettes
Quit: Date_____
Never
□ Current: Smoker: packs/day____ # of yrs _____

Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes

Alcohol Use
Do you drink alcohol? □ No □ Yes: # drinks/week_____
Is alcohol use a concern for you or others? □ No □ Yes

Drug Use
Do you use any recreational drugs? □ No □ Yes
Have you ever used needles? □ No □ Yes

EXERCISE:
Do you exercise regularly? □ No □ Yes

SOCIOECONOMICS:

Occupation: _____

Education completed: □ Grade school □ High school
□ College □ Graduate school
Years of education ____

Marital status: □Single □M □Sep □D □W □Co-habiting
□Engaged…□Other: _____

Spouse/Partner's name: _____
Number of children: _____
Who lives at home with you?_____

SEXUALITY

Sexual Activity

Sexually Active: Yes No Not currently
Current sex partner(s) is/are: male female

Contraception and Protection

Birth Control method:_____ □ None needed
If sexually active, do you practice safe sex? □ NA □ No □ Yes
Have you ever had any sexually transmitted diseases (STDs)?
□ No □ Yes

If yes, please include:
_____date_____
_____date_____

Are you interested in being screened for sexually transmitted diseases? □ No □ Yes

Other concerns?_____
_____

SAFETY:

Do use seatbelts consistently? □ No □ Yes
Do you use a bike helmet regularly? □ NA □ No □ Yes
Is violence at home a concern for you? □ No □ Yes
Do you feel safe in your current relationship? □ NA □ No □ Yes
Do you have a gun in your home? □ No □ Yes

Other concerns?_____
_____

EMOTIONS:

1. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? □ No □ Yes
2. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? □ No □ Yes
3. Have you felt depressed or sad much of he time in the past year? □ No □ Yes

IMMUNIZATIONS:

Please list your most recent immunizations. You do NOT need to include any immunizations given at Harvard Vanguard Medical Associates. Please include your best estimate of the month and year of each immunization:

Hepatitis A ____
Hepatitis B ____
Tetanus (Td) ____
Measles ____Mumps____Rubella____
MMR____
Varicella (chicken pox) shot ____
Pneumovax (Pneumonia)____
Other ____

REVIEW OF SYSTEMS: Please check (√) any current problems you have on the list below.

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Fatigue/weakness
___Excessive thirst or urination
Eyes
___Change in vision
Ears/Nose/Throat/Mouth
___Difficult hearing/ringing in ears
___Problems with teeth/gums
___Hay fever/allergies
Cardiovascular
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations
Chest (breast)
___Breast lump/discharge
Respiratory
___Cough/wheeze
___Difficulty breathing
Gastrointestinal
___Abdominal pain
___Blood in bowel movement
___Nausea/vomiting/diarrhea
Genitourinary
___Nighttime urination
___Leaking urine
___Unusual vaginal bleeding
___Discharge: penis or vagina
___Sexual function problems
Musculo-skeletal
___Muscle/joint pain
Skin
___ Rash or mole change
Neurological
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination
Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression
Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding
*Other (please specify)*_____
_____