Adult General History Form

Name:	Date of Birth:	Date:
Active Problems:		
Past Major Medical Problems:		
Surgeries:		
Medications, herbs, and supplements used:		
Allergies: (to medicine, environment, food and other)		

Family History	Age at death	Check if they had					Other medical conditions (for example, ADHD, Anemia, Autism, Bipolar, Cerebral Palsy, Depression, Bleeding Problems, Down Syndrome, Headaches, High Blood Pressure, High Cholesterol, Kidney Problems, Liver Disease, Seizures, Thyroid)
		Heart disease	Stroke	Diabetes	Osteoporosis	Cancer	
Father							
Mother							
Brother							
Sister							

Social History					
Marital Status:	Single ☐	Married ☐	Separated ☐	Divorced ☐	Widowed ☐
Occupation:_____	☐ Retired	☐ Disabled	☐ Unemployed		
Drug Use:	☐ Never use ☐ Recovering addict	I currently use… ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other_____			
Alcohol:	☐ Never Drank ☐ Rarely Drink ☐ Daily drinker ☐ Weekend drinker ☐ Recovering Alcoholic				
Smoking:	☐ Never Smoked ☐ Used to Smoke ☐ Smoke Sometimes ☐ Smoke Every Day Quit Year:				

** Please bring your immunization records to office visit, thank you **