

Martha Jefferson Medical Group

Adult COMPREHENSIVE HEALTH HISTORY

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|---|---|---|
| Patient Name: | Patient Date of Birth: | |
| Form completed by: | Date Completed/updated | |
| <p>As part of routine healthcare, we encourage every person over 18 to have an advance directive. To be useful, this document should name someone you trust to make decisions for you if you are ever unable to make decisions for yourself.</p> <p>Do you have an advance directive? YES NO If yes, please bring or mail a copy to our office.</p> | | |
| Personal Medical History (include year if known) | | |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | Heart | <input type="checkbox"/> Prostate Condition |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Reflux/Heartburn |
| <input type="checkbox"/> Cancer (type) | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Valve Problem/Heart Murmur | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disorder |
| | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other: |
| Eye/Vision | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Incontinence | |
| <input type="checkbox"/> Glaucoma | | Pregnancies(##) ____ Live Births(##) ____ |
| <input type="checkbox"/> Macular Degeneration | | |

| Current Medications/Vitamins/Herbs/Supplements | | | | | | |
|--|------|-----------|--|--------------------|------|-----------|
| Name of Medication | Dose | Frequency | | Name of Medication | Dose | Frequency |
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| Allergies | | |
| Allergies to Medications | <input type="checkbox"/> Latex | Environmental/Seasonal Allergies |
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| What is your preferred local pharmacy? | | |
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| Surgeries (include year if known) | | |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Ovary (right/left) removed |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Hernia | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal ligation (BTL) |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Vasectomy |
| | | Other: |

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|---|------------------------------|
| Patient Name: _____ | Patient Date of Birth: _____ |
| Major Injuries/Fractures (include year if known) | |
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| Family Medical History | | | |
| <input type="checkbox"/> No knowledge of blood relative history | | <input type="checkbox"/> Adopted | |
| Father: | <input type="checkbox"/> Living Age: _____ Major Illnesses: _____ | <input type="checkbox"/> Deceased Age: _____ | Cause of death: _____ |
| Mother: | <input type="checkbox"/> Living Age: _____ Major Illnesses: _____ | <input type="checkbox"/> Deceased Age: _____ | Cause of death: _____ |
| Brother(s): | <input type="checkbox"/> Living Age: _____ Major Illnesses: _____ | <input type="checkbox"/> Deceased Age: _____ | Cause of death: _____ |
| | <input type="checkbox"/> Living Age: _____ Major Illnesses: _____ | <input type="checkbox"/> Deceased Age: _____ | Cause of death: _____ |
| Sister(s): | <input type="checkbox"/> Living Age: _____ Major Illnesses: _____ | <input type="checkbox"/> Deceased Age: _____ | Cause of death: _____ |
| | <input type="checkbox"/> Living Age: _____ Major Illnesses: _____ | <input type="checkbox"/> Deceased Age: _____ | Cause of death: _____ |

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|----------------------------------|------------------------------------|---|---------------------------------------|
| Vaccinations | | | |
| <input type="checkbox"/> Flu | <input type="checkbox"/> Pneumovax | <input type="checkbox"/> Hepatitis B | Meningitis |
| <input type="checkbox"/> Tetanus | <input type="checkbox"/> Zostavax | <input type="checkbox"/> Gardasil (HPV) | <input type="checkbox"/> Other: _____ |

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| Medical Testing (include year of most recent if known) | | |
| <input type="checkbox"/> Mammogram | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> PSA (Prostate cancer screening) |
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Sigmoidoscopy | |
| <input type="checkbox"/> Bone Density test | <input type="checkbox"/> Stool blood test | |
| | <input type="checkbox"/> Exercise Stress Test | |
| | <input type="checkbox"/> HIV test | |

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| Social History | | | | |
| Marital Status: | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |
| Currently: | <input type="checkbox"/> Employed | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Retired | <input type="checkbox"/> Disabled |
| Occupation (list previous if retired): _____ | | | | |
| Tobacco: | <input type="checkbox"/> None | <input type="checkbox"/> Smoke | <input type="checkbox"/> Chew | <input type="checkbox"/> Quit When |
| Alcohol: | <input type="checkbox"/> None | <input type="checkbox"/> Occasional | <input type="checkbox"/> 1-2 /day | <input type="checkbox"/> More than 2/day |
| Recreational Drugs: | <input type="checkbox"/> None | <input type="checkbox"/> Yes | | |
| Exercise: | <input type="checkbox"/> None/Occasional | <input type="checkbox"/> Less than 3 days/week | <input type="checkbox"/> 3+ days/week | |
| Type: | | | | |
| Daily stress level: | Low | 1 | 2 | 3 |
| | 4 | 5 | 6 | 7 |
| | 8 | 9 | 10 | High |

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| Is there anything about your medical or personal history that you would like your health care provider to know? |
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