
Name

Date

**St. Mark's Millcreek Primary Care
Adult Health History Form**

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

Date of Birth: _____

How would you rate your general health? Excellent Good Fair Poor

Main reason for today's visit: _____

Other concerns: _____

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

Medication/Vitamin/Supplement	Dose/Strength (e.g., mg/pill)	How many times per day

ALLERGIES: Do you have allergies or reactions to:

Medications	Reaction

Foods	Reaction

MEDICAL HISTORY:

SURGICAL HISTORY:

Major Illnesses: (i.e. high blood pressure, high cholesterol, depression, etc.)	Year of Diagnosis	Currently Treated?	Surgeries:	Year of Surgery	Reason for Surgery
1			1		
2			2		
3			3		
4			4		
5			5		

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

- Alcoholism _____
- Cancer, specify type _____
- Heart disease _____
- Depression/suicide _____
- Genetic disorders _____
- Diabetes _____
- Kidney disease _____

- High cholesterol _____
- High blood pressure _____
- Stroke _____
- Bleeding/clotting disorder _____
- Asthma/COPD _____
- Anxiety _____
- Other: _____

Women's Health:

- # Pregnancies: _____
- # Deliveries: _____
- # Abortions: _____
- # Miscarriages: _____
- Age at start of periods: _____ Age at end of periods: _____
- Last Menstrual Cycle: _____
- Last Pap Smear: _____

Immunizations: (Approximate dates are fine)

- Date of your last flu shot: _____
- Date of your last pneumonia shot: _____
- Date of your last tetanus shot: _____

Health Maintenance:

- Date of your last physical: _____
- Date of your last colonoscopy: _____

SOCIAL HISTORY:

Tobacco Use

Cigarettes Never Quit Date _____
 Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? Yes No

Alcohol Use

Do you drink alcohol? Yes No # drinks/week _____
Is your alcohol use a concern for you or others? Yes No

Drug Use

Do you use any recreational drugs? Yes No
Have you ever used needles to inject drugs? Yes No