Door County
Medical Center

Adult Medical History

Please complete the attached form and provide our staff with an accurate,
up to date health history.
This information will be used to update your electronic medical record.
This tool will help us continue to provide excellent care to you and your family.

Patient Name____**DOB**______________

Today's Date_______________ **Name of Provider you are seeing**__________________

Personal Medical History (please circle all that apply)

Neurological:		
Cerebrovascular disease (stroke)	Headaches	Peripheral Neuropathy
Concussion	Multiple sclerosis	Seizure disorder
Dementia	Parkinson's disease	TIA (mini stroke)
Cardiac:		
Arrhythmia	Congestive heart failure	Hyperlipidemia
Atrial fibrillation	Cardiomyopathy	Peripheral vascular disease
Coronary artery disease	Hypertension	Valvular heart disease
Ear/Nose/Mouth/Throat:		
Alergic rhinitis	Chronic sinusitis	Macular degeneration
Cataracts	Glaucoma	Retinopathy
Chronic otitis	Hearing loss	
Respiratory:		
Asthma	Emphysema	Pulmonary fibrosis
COPD	Pneumonia	Sleep apnea
Chronic bronchitis	Pulmonary hypertension	
Gastrointestinal:		
Chronic constipation	Diverticular disease	Irritable bowel disease
Chronic diarrhea	GERD (reflux)	Inflammatory bowel disease
Cirrhosis	GI bleed	Pancreatitis
Colon polyps	Hemorrhoids	Peptic ulcer disease
Crohn's Disease of Colon		
Genitourinary		
BPH	ESRD (end stage kidney disease)	Kidney stones
Chronic renal disease (kidney)	Incontinence	Recurrent UTI's
Reproductive:		
Abnormal PAP smears	Fibroids	Polycystic ovarian syndrome
Dysmenorrhea	Menstrual disorder	Pelvic inflammatory disease
Endometriosis	Ovarian cyst	Sexually transmitted disease
Musculoskeletal:		
Arthritis	Fibromyalgia	Osteopenia
Chronic back pain	Gout	Osteoporosis
Chronic pain syndrome	Osteoarthritis	Rheumatoid arthritis
Endocrine:		
Gestational diabetes	Hyperthyroidism	Type 1 DM (diabetes)
Hypothyroidism	Obesity	Type 2 DM (diabetes)
Hematology:		
Anemia	Deep vein thrombosis	PE (pulmonary embolism)
Bleeding disorder	Hemophilia	Thrombocytopenia
Integument:		
Acne	Eczema	Rosacea
Chronic dermatitis	Psoriasis	Warts

Psychosocial:		
Alcohol abuse	Bipolar disorder	Nicotine dependence
ADD	Depression	Obsessive compulsive disorder
ADHD	Drug Abuse	PTSD
Anxiety	Eating disorder	
Cancer:		
Breast cancer	Leukemia	Prostate cancer
Colon cancer	Lung cancer	Sarcoma
Head/Neck cancer	Lymphoma	Skin cancer
Infectious:		
Hepatitis	HPV	Shingles
Herpes	Lyme disease	Tuberculosis
HIV	MRSA	

Family History:

Please add relation and check all conditions that apply

Relation: **(ie: brother, sister, etc)**	**Mother**	**Father**			
Age of family member:					
Alive					
Alive and well					
Deceased					
Bleeding disorder					
Breast Cancer					
CAD (coronary artery disease)					
COPD (chronic obstructive pulmonary disease)					
Cerebrovascular accident					
Clotting disorder					
Colon cancer					
Diabetes					
Hypertension					
Hyperlipidemia					
Myocardial infarction (heart attack)					
Mental health					
Ovarian cancer					
Prostate cancer					
Substance abuse					
Thyroid problems					

Adult Social History: Circle your responses

Are you a caregiver/ support person:	Yes	No
Members of your household:		

Spouse Significant Other Family Children Friend(s)
Caregiver Adopted Family Foster Family None

Do you live independently? Yes No

Marital Status:
Single Married Life Partner Legally Separated Divorced
Widowed Civil Union Common Law Marriage
Number of Children:______________

Education Level:
College Elementary School High School Middle School Vocational
Master's Degree

Current Occupational Status:
Employed Unemployed Student Retired Disabled

Current Occupation_________________________

Current Occupational Hazards/Exposures: Yes No

Dietary Habits
Diet is: Low Fat Low Sodium ADA Other

Exercise:
Physical Activity:
Walking Running Bicycling Swimming Yoga Aerobics
Weight Training None Other_________________ Additional_________________

Frequency:
1-2 times/week 3-4 times/week 5-6 times/week Daily

Durations:
<15 min/day 15-30 min/day 30-45 min/day 45-60 min/day
60-90 min/day >90 min/day Other

Tobacco:
Current every day smoker Current some day smoker Former smoker
Never Smoker Secondhand smoke Exposure Chewing Tobacco

Years Smoked:_____________

Smoking Status continued

How long ago did patient quit smoking_________________________________

Quit Status Considering Quitting Not Considering Quitting Quit Date Established
Has Quit before

Second Hand Exposure: Yes No

Alcohol Intake Current Never Former
Alcohol Intake Frequency Does not drink Former Alcohol drinker 0-2 drinks per day 2+ drinks per day A few times a week A few times a month Holidays/special occasional only Other
Substance Abuse Does not use Former substance user Marijuana Crack/Cocaine Heroin Amphetamines Hallucinogens Tranquilizers Sedatives Opiates Painkillers Club/Designer Drugs Inhalants IV drugs Methamphetamine Prescription Drug Unknown Other
Personal Safety Do you feel safe at home Yes No

Have you received HPV injection? **Yes** **No**

Are you sexually active? **Yes** **No**

Number of current partners___________

Number of lifetime partners__________

Past Surgery/Event History:

Surgery/Event	Date of Surgery/Event	Name of Facility (treatment was given)	Surgeon's Name (if applicable)

ALLERGIES

Food Allergies:____

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____

Other Allergies:____

____

____

Drug Allergies **Yes** **No**

Drug Allergy **Describe Reaction**

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____

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MEDICATIONS

Preferred Pharmacy____

FOR FEMALES ONLY:

How many pregnancies___________ How many births_________ How many term_______

Pre-term________________ Multiple births__________ Living Children______________

Abortions______________ Miscarriages____________ Ectopic pregnancies___________

C-sections_______________ Currently pregnant? Yes No Estimated due date_________

Last menstrual period__________________
Birth Control: None Diaphragm Menopause Pill Abstinence Implanon IUD
Ortho Evra Tubal Natural Family Planning Depo Provera Vasectomy
Withdrawal Nuva Ring Adiana Mini pill Mirena IUC Hysterectomy
Condom Paraguard IUD Other___________________________

Age menses started:_________________ Ages menses stopped:__________________

Past History
Self-Breast exams Yes No Mammogram Yes No Normal Pap Smears Yes No

Abnormal PAP < 5 yrs ago Yes No History of ovarian cysts Yes No