NORTH COAST FAMILY MEDICAL GROUP, INC.
ADULT/ADOLESCENT HISTORY

Today's Date____________

Name of prior Physician: ________________________
Date last seen: ________________________
Reason for leaving: ________________________

Name: ________________________
D.O.B ________________________
Sex: □ **Female** □ **Male** **Age:** __________

ADVANCED DIRECTIVE: Do you have an Advanced Directive/ Durable Power of Attorney for health care? □ Yes □ No

MEDICAL HISTORY: Please check the appropriate box if you have had or currently have any of the conditions below.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
□	□	Acne	□	□	Large prostate	□	□	Lung disease
□	□	Allergies	□	□	Gallstones	□	□	Menstrual disorder
□	□	Anemia	□	□	Glaucoma	□	□	Migraines
□	□	Anxiety	□	□	Gout	□	□	Osteoporosis
□	□	Arthritis	□	□	Heart arrhythmia	□	□	Peptic (stomach) Ulcer
□	□	Asthma	□	□	Heart attack	□	□	Pancreatitis
□	□	Blood disorder	□	□	Heart disease	□	□	Peripheral Artery Disease
□	□	Cholesterol high	□	□	Heart murmur	□	□	Reflux/heartburn
□	□	Chronic pain	□	□	Hepatitis	□	□	Rosacea
□	□	Depression	□	□	Hernia	□	□	Sinus infections, recurrence
□	□	Diabetes	□	□	Herpes	□	□	Skin cancer: ______________
□	□	Diverticulosis	□	□	Hypertension	□	□	Stroke
□	□	Eating disorder	□	□	Irritable bowel	□	□	Thyroid disorder
□	□	Eczema	□	□	Kidney disease	□	□	Tuberculosis positive skin test
□	□	Emphysema	□	□	Kidney stones	□	□	UTI recurrence
□	□	Substance abuse: ______________						
□	□	Cancer: ______________						
□	□	Other: ______________						

CURRENT MEDICATIONS: List all current medications or any supplements/vitamins you are currently taking. Please include their dosages and frequency. (EX: Aspirin 81mg daily; Calcium + vitamin D 1200mg daily)

Medication/Supplement	Dosage	Frequency	Reason for taking	Date started

ALLERGIES: List any allergies you may have to medications/food, along with the reaction. (EX: Penicillin, hives)

Medication/Food Allergy	Reaction	Medication/Food Allergy	Reaction

SURGICAL AND PROCEDURAL HISTORY: Please note any surgeries and/or procedures, and include their dates. (EX: 1/2000- Right total knee replacement; 2/2001- colonoscopy, normal; 3/2002 -blood transfusion, 4/2004- treadmill test)

Date	Surgery/Procedure	Date	Surgery/Procedure

HOSPITALIZATIONS: Please list the dates and reason for hospitalization. (EX: 4/2003 Pneumonia)

Date	Reason for admission	Date	Reason for admission

IMMUNIZATIONS: Please check the box and write in the dates if you have had any of the vaccines below.			
Vaccine	**Date Given**	**Vaccine**	**Date Given**
□ Influenza (Flu shot)		□ Pneumococcal (Pneumonia)	
□ Human papillomavirus (Gardasil)		□ Tetanus, diphtheria, pertussis	
□ Measles, Mumps, Rubella		□ Varicella (Chicken pox)	
□ Meningococcal (Meningitis)		□ Zoster (Shingles)	

WOMEN'S HEALTH:	
Date of last pap test:	Ever had an abnormal pap: □ No □Yes, dates: ____ Treatment_________
Form of birth control:	Menstrual cycles: □ Regular □ Irregular □ Menopause at age: ______
Date of last mammogram:	Date of last bone density test:
OBSTETRIC HISTORY: Number of Pregnancies:	
Years of birth(s):	Number of Miscarriages:
Number of Living children:	Number of Therapeutic Abortions:
Number of Vaginal births:	Number of C-sections:

FAMILY HISTORY: Please check the boxes that apply to your family									
Family member	**Alive**	**Year of birth**	**Breast cancer**	**Diabetes**	**Heart disease**	**Colon cancer**	**Asthma**	**Ovarian cancer**	**Other**
Father:	□								
Mother:	□								
Brother:	□								
Sister:	□								
Children	□								
Paternal Grandfather:	□								
Paternal Grandmother:	□								
Maternal Grandfather:	□								
Maternal Grandmother:	□								
Other:	□								

SOCIAL HISTORY:	
Background	Where were you born? Where did you grow up?
Marital Status	□ Single □ Married □ Separated □ Divorced □ Widowed How many children?_____
Occupation	
Exercise	(type and frequency)
Hobbies	
Tobacco	□ No □ Yes □ Smoked in past, but quit in ___________ Number packs per day _______ Number years _______ Ready to quit? ____________
Alcohol	□ No □ Yes ______ glasses/day OR _____ glasses/week. Any problems due to alcohol? □ No □ Yes, please explain: ___________________________ Ready to quit? ____________
Recreational Drugs	□ No □ Yes, please explain: _____________________________ Ready to quit? ____________
Domestic Violence	Are you involved in domestic violence □ No □ Yes, please explain: ________________________

REVIEW OF SYSTEMS: Please check if you have any of the symptoms below **regularly or out of the ordinary.**				
Constitution	□ blurring of vision	**Gastroenterology**	□ dryness	□ redness
□ headache	□ sudden blindness	□ abdominal pain	□ rash	□ cramps
□ dizziness	□ double vision	□ vomiting	□ bruising	□ muscle/tendon injury
□ fainting	**Endocrinology**	□ diarrhea	□ changing/new mole	**Psychiatry**
□ fatigue	□ excessive thirst	□ bloody or black stool	**Neurology**	□ nerves
□ weight change	□ cold intolerance	□ constipation	□ paralysis	□ depression
□ fever	□ heat intolerance	□ jaundice	□ numbness	□ insomnia
Ears/nose/throat	**Cardiology**	**Urology**	□ weakness	□ anxiety
□ hearing loss	□ chest pain	□ bloody/dark urine	□ convulsions	**Women's Health**
□ ringing in the ears	□ palpitations	□ burning	**Hematology/Lymph**	□ spotting
□ loss of balance	**Respiratory**	□ increased frequency	□ bleeding	□ painful intercourse
□ nose bleeds	□ cough	□ incontinence	□ swollen glands	□ severe cramps
□ chronic drainage	□ wheeze	□ decreased flow	**Musculoskeletal**	□ breast lumps
□ sore throat	□ shortness of breath	□ dribbling	□ frequent back pain	□ breast pain
□ difficulty swallowing	□ chronic phlegm	□ erectile dysfunction	□ sciatica	□ breast discharge
Eyes	□ coughing up blood	**Dermatology**	□ extremity swelling	□ vaginal discharge