Adult Medical History (18 years or older) W Brad Gates, MD, PA

This information is collected to better care for you. All records are kept confidential.

Name: _____ Preferred Name: _____ Date: _____

Date of Birth: _____ Sex: M F Marital Status: Single Married Separated Divorced Widowed

Place of Birth: _____ Religious Preference: _____

Education: _____ Employer: _____

I was referred to the practice by: _____

Pharmacy (name/intersection): _____ Mail Order (name/location): _____

Members in your household:

Name	Relationship	Age	Occupation/Education

Past medications not tolerated: _____

Medications (include herbs and OTC)	Dose	Diagnosis	How long have you taken it?

Hospitalization/Surgery/Major Illnesses	Where	Year

Have you had chicken pox? Y N Unsure Recent immunizations _____

Year of last tetanus booster: _____ physical exam: _____ dental exam: _____ eye exam: _____ colonoscopy: _____

Do you wear contacts, glasses or dentures? _____

Caffeine use (type, quantity): _____

Alcohol intake (type, servings per day): _____

Tobacco use (type, quantity, years and year quit): _____

Recreational drug use (type, years and year quit): _____

Exercise (type, frequency): _____ Hours of sleep: _____

Special diet: _____ Foreign travel in the last 6 months: _____

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Patient Name: _____ Date of Birth: _____

Family History (including parents, siblings, grandparents, aunts and uncles):

Heart attack: _____

Diabetes: _____

Cancer (type): _____

Other: _____

Deceased family members with age and cause: _____

Symptoms: (circle if applicable)

Weight gain or loss
Increased thirst
Fainting or black outs
Seizures
Frequent falls
Dizziness
Weakness or fatigue
Hair loss or changes
Rash or skin changes
Easy bruising or bleeding
Unusual sweating or night sweats
Unusual lumps or bumps
Trouble sleeping
Snoring
Daytime sleepiness
Anxiety
Depression
Suicidal thoughts
Significant Stress
Cry frequently
Decreased motivation or interest
Poor memory
Frequent headaches
Eye/vision problems
Ear/hearing problems
Dental/mouth problems
Nasal problems
Sore throats
Hoarseness
Tuberculosis or positive test
Cough
Asthma/wheezing
Shortness of breath
Pneumonia
Chest pain
Irregular of fast heart beat
Trouble swallowing
Heartburn
Stomach problems
Constipation
Diarrhea
Change in stools
Hemorrhoids
Urinary problems
Sexually active
History of STD
Back or neck problems
Swelling
Leg cramps or problems
Joint pain
Gout
Numbness or tingling
Tremor or shakiness
Bone fractures

For Men:

Prostate problems
Discharge from penis
Testicular pain or lump
Erectile problems

For Women:

Breast lump or pain
Nipple discharge
Abnormal pap smear
Spotting between periods
Discharge
Pain with intercourse
Hot flashes or menopause
Bleeding after menopause
Pelvic infections
Trouble conceiving

Last Pap smear: _____ Last Mammogram: _____ Monthly self-breast exams (circle one): Y N

Last bone density test: _____Last period: _____ Contraception type: _____

Number of pregnancies: _____ Deliveries: _____ Miscarriages: _____ Abortions: _____ Still births: _____