OSTEOPATHIC
FAMILY WELLNESS CENTER

Adult Medical History Form

PLEASE FILL IN EVERY SECTION TO THE VERY BEST OF YOUR KNOWLEDGE

1. **Name:** _____ **DOB:** _____/_____/_____
   (First, Middle, and Last Name)

   Is this your first visit to Osteopathic Family Wellness Center? ☐ Yes ☐ No

   How did you hear about us? _____

2. **Reason for Today's Visit:** _____

Medical History

3. **Allergies:**

   Drug Allergies: _____

   (Penicillin, Acetaminophen, Sulfa Drugs, NSAIDS, Ibuprofen)

   If yes, What type of allergic reaction do you experience: _____

   Food: _____

   (Dairy, Egg, Peanuts, Shellfish, Soy, Wheat, Melon, Gluten)

   If yes, What type of allergic reaction do you experience: _____

   Environmental:_____

   (Dust, Pollen, Animal Dander, Insects)

   If yes, What type of allergic reaction do you experience: _____

   Contact:_____

   (Latex)

   If yes, What type of allergic reaction do you experience: _____

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4. **Medications:** Please list all medications you currently take, DOSAGE/ STRENGTH and How many you take /directions: (Prescriptions, Vitamins, Supplements, Herbs)

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5. **Social History:**

Ethnic Background: ☐ White/Caucasian, Non-Hispanic ☐ Black, Non-Hispanic
☐ Hispanic/Latino ☐ Native American
☐ Native Hawaiian ☐ Asian ☐ Other

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6. **Tobacco Use**:

☐ Never Smoker (Skip to Section 7)

☐ Former Smoker: How many packs per day:_____

☐ Current Smoker: How many packs per day:_____

Tobacco Type: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew/Snuff

Have you felt the need to quit? ☐ Yes ☐ No

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7. **Alcohol Use:**

Do you drink Alcohol: ☐ No (Skip to section 8)
☐ Yes (Complete this section in it's entirety)

Type of Alcohol: ☐ Beer ☐ Wine ☐ Hard Liquor

How much Alcohol do you consume in Ounces? _____

How often do you consume Alcohol? _____

Have you felt the need to quit? ☐ Yes

☐ No

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8. Illicit Drug Use:

Do you use any kind of illicit drugs? ☐ No (Skip to section 9)

☐ Yes (Complete this section in it's entirety)

What is the name of the drug? _____

How often is this drug consumed? _____

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9. Marital Status:

☐ Single ☐ Married/Living with Partner ☐ Separated ☐ Divorced ☐ Widowed

10. Children

Do you have offspring? ☐ No (Skip to Section 11)

☐ Yes (Complete this section in its entirety)

How many offspring do you have? _____

How many are Female? Male? _____

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11. Sexual Activity:

Are you sexually active? ☐ Yes ☐ No

Preferred Partners: (check all that apply) ☐ Male ☐ Female ☐ FTM ☐ MTF

Contraceptive: ☐ Pill/Patch/NuvaRing ☐ Barrier Method

☐ IUD ☐ Implant ☐ Sterilization

HPV/ Hepatitis B Vaccination? _____

Have you ever had a sexually transmitted infection?

☐ No ☐ Yes; Which STD: _____

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12. Occupation:

Are you currently employed: ☐ Yes ☐ No

What industry do you work in? _____

Do you work Fulltime, Part time, Per Diem? _____

What is your Job Title? _____

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13. Surgical History:

Have you ever had a surgery? ☐ No (Skip to Section 14)

☐ Yes (Please complete this section in its entirety)

Surgery Name	Date	Surgery Name	Date

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14. Women Only (If male, skip to section 15)

Are you pregnant? ☐ Yes ☐ No

No. of Pregnancies: _____No. of Miscarriages: _____

No. of Deliveries: _____No. of Abortions: _____

First Day of Last Menstrual Period: _____ Frequency of Periods: _____

Length of Periods: _____

Last pap smear: ___/_____/___

Abnormal PAPS: ☐ Yes ☐ No Year_____

Last mammogram done: _____

OSTEOPATHIC FAMILY WELLNESS CENTER

15. Personal AND Family History:

Please include: (Mother, Father, Paternal or Maternal Grandmother, Grandfather)

Disease	Me	Family member	Alive?	**Disease**	Me	Family member, who?	Alive?
ADHD/ADD				GERD/ Acid reflux			
Alcoholism				Hay Fever (Allergies)			
Anemia				Headaches/Migraines			
Anxiety				Hearing Problems			
Arthritis				Hepatitis			
Asthma/COPD				High Blood Pressure/HTN			
Back Pain				High Cholesterol			
Bipolar Disorder				Kidney Disease			
Cancer:				Lupus (SLE)			
Breast				Migraine/ Headaches			
Colon				Mitral Valve Prolapse			
Lung				Obsessive Compulsive Disease			
Skin				Osteoporosis			
Prostate				Panic Attacks			
Other Cancer				Polycystic Ovarian Syndrome PCOS			
Colon Polyps				Schizophrenia			
Dementia				Skin Disease			
Depression				Stroke			
Diabetes				Suicide Attempt			
Drug Addiction				Thyroid Disorders			
Eating Disorder				Tuberculosis			
Epilepsy				Ulcer			
Glaucoma				Other:			