St. Clair Health
St. Clair Medical Group

Adult Medical History Form

Patient Legal Name ________________________________ **Patient Date of Birth** ______________

Pharmacy for Prescription Medications: ________________________________

Primary Care Provider: ________________________________

Reason for visit: ________________________________

Please describe what brings you into the office today: ________________________________

If applicable, please describe the symptoms and/or affected area: ________________________________

If applicable, when did this problem begin? ________________________________

Past Medical History: *Please check the boxes of any medical problems that you currently have or experienced in the past*

- ☐ Cancer
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Pneumonia
- ☐ Seizure Disorders
- ☐ Ulcers
- ☐ Gastric Reflux / GERD
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Blood Clots (DVT or PE)
- ☐ Bleeding Disorder
- ☐ Congestive Heart Failure
- ☐ High Cholesterol
- ☐ Peripheral Vascular Disease
- ☐ Hepatitis A / B / C
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fractures
- ☐ Thyroid Disease
- ☐ Immune Disorder
- ☐ Multiple Sclerosis
- ☐ Alcoholism
- ☐ Mental Illness
- ☐ Depression / Anxiety

Other: ________________________________

Past Surgical History:

Year	Type of Operation

Medications:

Current Medication	Dose	Frequency	Current Medication	Dose	Frequency

Allergies:

	Allergy	What reaction did you have?

Family History: *Please check the illnesses that have occurred in any of your blood relatives & specify which relatives(s).*

- ☐ Cancer
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ COPD / Emphysema
- ☐ Pneumonia
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- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fractures
- ☐ Thyroid Disease
- ☐ Immune Disorder
- ☐ Multiple Sclerosis
- ☐ Alcoholism
- ☐ Mental Illness
- ☐ Depression / Anxiety

Other:____

Social History:

What is your work status *(please select one)?*

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student ☐ Homemaker

What is your occupation? ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

☐ Widowed ☐ Domestic Partner

Do you have any children? ☐ Yes ☐ No If so, how many? ______________

Who lives at home with you? ______________________________

Do you currently use tobacco? ☐ Yes ☐ No Did you previously use tobacco? ☐ Yes ☐ No

Cigarettes ______pack/day ☐ Pipe ☐ Cigar ☐ Chewing Tobacco Number of years? _______

☐ Vaping Quit Date? ____________

Do you use alcohol ☐ Yes ☐ No __________________

If yes, # of drinks?____Daily ________Weekly ____________Monthly ____________

Do you use any street drugs? ☐ Yes ☐ No

If yes, describe ______________________________

Do you have any history of drug or alcohol abuse? ☐ Yes ☐ No

If yes, describe: ______________________________

Mental Health: *Over the last 2 weeks, how often have you been bothered by either of the following problems?*

Please use "X" to indicate your answer	Not at All (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1) Little interest or pleasure in doing things				
2) Feeling down, depressed, or hopeless				

Women's Health: (for females only)

Date of Last Menstrual Period (if applicable): ______________________________

Are you planning pregnancy? ☐ Yes ☐ No

Birth control method & product name (if applicable): ______________________________

Number of pregnancies: __________________ Number of living children: ______________________

Health Maintenance / Testing:

Test or Vaccine (as applicable)	Approximate Date & Results (if known)
Pap / Pelvic Exam	
Mammogram	
Colonoscopy or other colon cancer screening test	
DEXA (Bone Density Test)	
Cholesterol Panel	
PSA	
Tetanus – Td or Tdap	
Influenza	

Specialists: *Please note any and all specialists that have previously or currently follow your care.*

	Specialty	Practice Name / Provider Name
	Cardiology	
	Endocrinology	
	Allergy & Immunology	
	Dermatology	
	Gastroenterology	
	ENT	
	Orthopedics	
	Obstetrics / Gynecology	
	Opthamologist	
	Neurology	
	Pulmonary	
	Psychiatry	
	Urologist	
	Other	

Patient Signature:____ **Date:** ___________________________