

Greene Family Medicine, PLLC
29 North Chenango St., Suite A
Greene, NY 13778
Greenefamilymed.com
Phone: (607) 875-4334

Adult Medical History Form

Name _____ DOB _____

***ALLERGIES (include type of reaction):

Past Medical History (circle all that apply) (write below any not listed)

heart disease	lung problem	diabetes	cancer
high blood pressure	asthma	stomach ulcers	stroke
congestive heart failure	emphysema	colitis	arthritis
heart valve problem	stroke	osteoporosis	missing limb/digit

Hospitalizations/ Include Surgeries

Date	Reason	Hospital Name/City
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications	Strength	when you take it	for what do you take	Prescriber
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Social History

Do you smoke ?
Did you ever smoke ?
How much ?
For how many years ?
Interested in quitting ?

Do you drink alcohol ?
How much ?
Has drinking alcohol ever caused you a problem ?
Has anyone told you that you drink too much ?
Do you use any other drugs (non-prescription) ?

Occupation (List Even if Retired) _____

Duties of your job _____

Family History/ List relationship/Age at Death

Cancer _____

Heart Problems _____

Bad reactions to anesthesia _____

Diabetes _____

Psychiatric difficulty _____

Tuberculosis _____

First name/Sex/Age of Children

Boys _____

Girls _____

Spouse/Partner/Significant other Name _____

Current Symptom Review (circle if you have these symptoms and describe)

Breathing problems

Depression

Chest problems/pain/heaviness

Anxiety

Bone/Joint problems

Unusual Headaches

Bowel or stomach problems

Weakness

Bleeding from rectum/in urine

Night sweats

Unexplained weight loss/Gain

Loss of Appetite

Swelling

Problems with sexual activity

Which hand do you write with ? L R

Medical Screening tests/ List year/facility/Doctor

Pap smear _____

Rectal exam _____

Blood sugar _____

Prostate exam _____

Cholesterol _____

Mammogram _____

Colonoscopy _____

Test for blood in stool _____

Testicular exam _____

Skin Check _____

Other Things you think I should know about you: