THE POLYCLINIC
Part of Optum®

Name: first middle last
______________________________

Date of birth: ___________

Age: _____________

Today's date: _________________

# Adult medical history form

Please print your responses on this form.

Job: ________________________________________

**Marital status:** ☐ married ☐ widowed ☐ divorced

**Drug allergies or reactions (bad response to medications):**

______________________________________________________________________________

______________________________________________________________________________

**Medical history** Please list any illnesses, long-term medical problems, time you spent in the hospital and major surgeries. Please include dates if you know them.

______________________________________________________________________________

______________________________________________________________________________

**Please check if you have had any of the following:**

☐ Diabetes ☐ High blood pressure ☐ Stroke ☐ Heart disease ☐ Lung problems
☐ Blood clots ☐ Seizures ☐ Depression, anxiety ☐ Cancer (type): ______________________

## FAMILY HISTORY

| Relative | Age if living | Age at death | Current condition or cause of death? |
|---|---|---|---|
| **Father** | | | |
| **Mother** | | | |
| **Brother(s)** | | | |
| **Sister(s)** | | | |
| **Child(ren)** | | | |

Number of brothers: ____________ Number of sisters: ____________ Number of children: ________________

**Please check if any relative had any of the following medical problems. If you check one, please note which relative:**

☐ Alcohol use disorder: ________________________ ☐ Alzheimer's: ________________________________________
☐ Anemia or low blood count: ___________________ ☐ Lung problems: _____________________________________
☐ Cancer, breast: _____________________________ ☐ Cancer, colon: ______________________________________
☐ Cancer, prostate (gland in male body that makes sperm): ____________________________________________________
☐ Cancer, other: ________________________________ ☐ Heart disease: _____________________________________
☐ Depression, anxiety (worrying more than normal): ______________________________________________________
☐ Bipolar disorder: ____________________________ ☐ Diabetes: __________________________________________
☐ Blood clots: _________________________________ ☐ Hearing loss: ______________________________________
☐ High blood pressure: __________________________ ☐ Stroke: ____________________________________________
☐ High cholesterol (substance in blood that can lead to heart disease): _________________________________________
☐ Osteoporosis: _______________________________ ☐ Other: ____________________________________________

**Please list current prescription medications, over the counter medications and herbal supplements that you take:**

______________________________________________________________________________

______________________________________________________________________________



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Are you taking aspirin daily? ☐ yes ☐ no    Do you have any objections to a blood transfusion? ☐ yes ☐ no

Birth control method: ______________________________________________________________________________

**Immunizations (shots)** Please list dates of your most recent shots.
flu: __________ tetanus: ___________ pneumonia: ___________ hepatitis A: __________ hepatitis B: ___________

## SOCIAL HISTORY

Exercise (physical movement): (type) ______________________How often do you exercise? ______________________
Smoking: ☐ yes ☐ no Packs per day: ________ How long have you smoked? _________________________
Type used: ☐ pipe ☐ cigar ☐ chew How long have you used this item? ___________________________
Number of years since you stopped smoking or using above items? ____________________________________________
Alcohol: Drinks per day: _________ Drinks per week: ________ Recreational drug use: ☐ yes ☐ no

## SAFETY

Do you use seatbelts in your car? ☐ yes ☐ no    Do you have smoke detectors in your house? ☐ yes ☐ no
Do you use Lifeline medical alert system? ☐ yes ☐ no
If you have weapons in your home, are they kept in a safe place? ☐ yes ☐ no ☐ do not have weapons

## SELF CARE

Please check if you **need someone's help** with any of the following:
☐ dressing, putting on clothes ☐ cooking meals ☐ bathing ☐ walking ☐ transportation, driving, getting around
Please check if you now have any of these advance directive forms or forms that state your health care wishes:
☐ Living will ☐ Durable power of attorney for health care ☐ Physician orders for life-sustaining treatment (POLST)

## GENERAL MEDICAL HISTORY

**Please check all terms that describe you and your health:**
**General health:** ☐ no problems ☐ fatigue ☐ weakness ☐ weight loss ☐ ankle swelling ☐ sleep problems
☐ other __________
**Mental health:** ☐ no problems ☐ memory problems ☐ depressed ☐ tense, nervous ☐ other _____________
**Brain and nerves:** ☐ no problems ☐ fainting ☐ poor balance ☐ one or more falls in past six months
☐ other ______________
**Urinary:** ☐ no problems ☐ leaking bladder ☐ difficulty urinating ☐ sexual difficulty or concern
☐ other ______________
**Bones and muscles:** ☐ no problems ☐ difficulty or pain with walking ☐ painful joints ☐ other __________
**Head and neck:** ☐ no problems ☐ hearing problems ☐ eyesight problem ☐ other __________
**Breathing:** ☐ no problems ☐ cough ☐ shortness of breath ☐ other __________
**Heart:** ☐ no problems ☐ chest pain or pressure ☐ irregular heartbeat or heartbeat that isn't normal
☐ leg pain with walking ☐ other _________________
**Stomach and bowels:** ☐ no problems ☐ swallowing trouble ☐ indigestion ☐ abdominal pain ☐ constipation
☐ diarrhea ☐ blood in stool or black stools ☐ other __________
**Skin:** ☐ no problems ☐ rash ☐ skin problems ☐ skin cancer ☐ other __________________________
**Other:** ☐ gonorrhea ☐ herpes ☐ chlamydia
**Women only:** ☐ no problems ☐ abnormal vaginal bleeding ☐ vaginal discharge (fluid leaking) ☐ abnormal pap
☐ hot flashes ☐ breast lump ☐ breast pain ☐ other ______________________________________________

_________________________________________________/_________________ Reviewed by MD, initials: ______
**Patient Signature** *(required*    **Date** *(required)*

Print patient name: ____________________________________ Date of birth: _____________________



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