north country healthcare | Weeks Medical Center

ADULT DATA BASE

PERSONAL HISTORY	Name		Birthdate
Marital status-	Nearest relative:	Their phone #:	
Occupation: []current [] retired		Work phone:	
Number of pregnancies: Full term__; Miscarriages___; Premature___; C-Sections___;Terminations__;Stillbirths__			
Children & their birth year:			
Who Lives in household with you?			
Education: (years)_______	Insurance		Religion

FAMILY HISTORY	*Age*	*Major health problems (if deceased, include cause of death)*
Mother		
Father		
Brothers/sisters		

Circle any of the following diseases which a blood relative has had

1. Heart attacks	5. Rheumatic fever	9. Goiter (thyroid)	13. Bleeding disorder	17. Other:
2. High blood pressure	6. Tuberculosis	10. Epilepsy/fits	14. Nervous breakdown	
3. Diabetes	7. Arthritis	11. Liver disease	15. Cancer	
4. Stroke	8. Gout	12. Kidney disease	16. Anemia/low blood	

PAST MEDICAL HISTORY	DATE	OPERATION /ILLNESS	HOSPITAL OR DOCTOR
OPERATIONS			
HOSPITALIZATIONS			
INURIES /FRACTURES			

MAJOR ILLNESSES: *Circle any of the following that you may have had*

1. Stroke	9. Rheumatic heart disease	17. Asthma	25. Diabetes	33. Urine infections
2. Seizure	10. High blood pressure	18. Pneumonia	26. Jaundice	34. Tuberculosis
3. Mental illness	11. Heart murmur	19. Seasonal allergies	27. Ulcers	35. Venereal disease
4. Depression	12. Heart attack	20. Anemia	28. Diverticulitis	36. Thyroid disease
5. Anxiety	13. Heart failure	21. Bleeding disorder	29. Gallbladder	37. Skin Conditions
6. Cataracts	14. Angina	22. Blood Clots	30. Irritable bowel	38. HIV/AIDS
7. Glaucoma	15. Tuberculosis	23. Arthritis	31. Kidney stones	39. Epilepsy
8. Cancer	16. Emphysema	24. Gout	32. Kidney Infections	

IMMUNIZATIONS: *(list year of last dose)*	**SCREENING EXAM:** *(list year done)*	
Tetanus shot	TB skin test	Stool test for blood
Flu shot	Heart EKG	Cholesterol test
Pneumonia shot	Pap smear	Breathing test (spirometry)
Hepatitis A	Mammogram	Sigmoidoscopy
Hepatitis B	Chest x-ray	Colonoscopy
Other:	Other x-ray	Vision test
		Hearing test

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MEDICATIONS: *Please list all your current medications, including all over-the-counter medications such as aspirin, Tylenol, vitamins, cold medicines and alternative medicines such as herbs*

Name of Medication	Dose	Times Per day

ALLERGIES: *Please list any medications, foods or other substances you are allergic to, or which caused major side effects. Include the type of reactions.*

Allergies	Reactions

IF YOU HAVE NO KNOWN ALLERGIES, CHECK HERE: ❑

OTHER INFORMATION:

Smoking	Do you smoke?	❑Yes ❑No	*If Yes,*	How much?________________	Would you like to quit?	❑Yes ❑No
	Have you ever smoked?	❑Yes ❑No	*If yes,*	When did you quit?__________		
Alcohol	Do you drink?	❑Yes ❑No	*If Yes,*	How much?________________	Would you like to quit?	❑Yes ❑No
Exercise	Do you exercise?	❑Yes ❑No	*If Yes,*	How much?____ What types of exercise?__________________________________		
Safety	Do you wear your seatbelt?			❑Yes ❑No		
	A helmet if you ride?			❑Yes ❑No		
Advanced Directives	Do you have any advanced directives? *(Living Will/Durable Power of Attorney?)*			❑Yes ❑No		

PATIENT'S SIGNATURE: ____ **DATE:**____________________

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