WESTSIDE FAMILY HEALTH CENTER
a california health center

ADULT MEDICAL HEALTH HISTORY FORM

PATIENT INFORMATION

Last Name: ______________________ First Name ____________________________ Middle Name ________

Preferred Name: ____________________________

Date of Birth: / / Gender: Sex assigned at birth:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

Emergency Contact Name: Relation:

Emergency Contact Phone:

Please use an "X" to mark your answers to the following question.

Have you (the adult) or the patient (the child) had?

[ ] A cough that's lasted longer than three weeks [ ] A cough that produces blood [ ] Active Tuberculosis

Please bring this form to the receptionist right away if you marked "Yes" to any of these items.

PATIENT'S MEDICAL AND SURGICAL HEALTH HISTORY

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

[ ]ADD/ADHD
[ ]Anxiety
[ ]Anemia
[ ]Arthritis
[ ]Asthma
[ ]Bladder problems
[ ]Bleeding disorders
[ ]Bone/Joint issues
[ ]Cancer
[ ]Cerebral Palsy
[ ]Chicken Pox
[ ]Chronic sinusitis
[ ]Depression
[ ]Diabetes
[ ]Epilepsy
[ ]Fainting
[ ]Growth problems
[ ]Hearing problems
[ ]Heart Issue
[ ]Heart Murmur
[ ]Hepatitis (A,B,C) circle one HIV/AIDS
[ ]Immunizations
[ ]Kidney problems
[ ]Liver problems
[ ]Measles
[ ]Mononucleosis
[ ]Mumps
[ ]Pregnancy
[ ]Rheumatic Fever
[ ]Seizures
[ ]Sexually transmitted infection (STI)
[ ]Sickle Cell Anemia
[ ]Thyroid issues
[ ]Tobacco/Vaping
[ ]Tuberculosis
[ ]Other: ______________
____

Circle your answers to the following questions

Question		
Is the patient pregnant or lactating?	Yes	No
Has the patient ever had surgery?	Yes	No
If yes, when and what type:		
Has the patient ever been hospitalized?	Yes	No
If yes, when and why:		
Has the patient ever been given a general anesthetic?	Yes	No
Has the patient ever had a blood transfusion?	Yes	No
Does the patient experience excessive bleeding when cut?	Yes	No
Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist? If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: Phone:	Yes	No
Does the patient have any genetic (inherited) conditions?	Yes	No
If yes, please explain:		
Does the patient have any speech difficulties?	Yes	No
If yes, please explain:		

WESTSIDE FAMILY HEALTH CENTER
a california health center

ADULT MEDICAL HEALTH HISTORY FORM

PATIENT'S FAMILY HISTORY

Has anyone in your family had trouble with the following?
Include mother (M), father (F), brother (B), sister (S), grandmother (GM), grandfather (GF)

Please check the box in front of any health conditions or issues the patient has now or has had in the past:

[ ] Cancer______ [ ] Heart attack______ [ ] High cholesterol______ [ ] Thyroid disease______
[ ] Depression______ [ ] Heart disease______ [ ] Stroke______ [ ] Other: ______
[ ] Diabetes______ [ ] High blood pressure______ [ ] Seizures______

Please list any other significant family history we should know about:

MEDICATIONS & ALLERGIES

Please use an "X" to mark your answers to the following questions (Yes? No?)

Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications?
[ ]Yes [ ]No If yes, please list them here: ____

Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications?
[ ]Yes [ ]No If yes, please list those medications and what happened when the patient took them:____________________________

Does the patient have other allergies, such as latex, metals, iodine, certain foods, animals, plants, etc.?
[ ]Yes [ ]No If yes, please describe the allergy and the reaction: ____

SOCIAL HISTORY

Circle your answers to the following questions

Have you had more than one sexual partner this year?	Yes	No
How many sexual partners have you had in the last year: Male# Female#		
Did you have unprotected intercourse with your last partner?	Yes	No
Have you ever had a sexually transmitted infection?	Yes	No
If yes, when and what kind:		
What method of birth control are you currently using:		
Do you smoke cigarettes?	Yes	No
If yes, how many cigarettes per day: How long:		
Do you drink alcoholic beverages?	Yes	No
If yes, how many drinks per day: Drinks per week: How long:		
Have you ever had a problem with substance abuse?	Yes	No
If yes, when:		
Have you and/or your partner ever used IV drugs?	Yes	No
If yes, when:		
Do you frequently or regularly go on a diet to gain or lose weight?	Yes	No
If yes, how often:		
Do you exercise regularly?	Yes	No
If yes, how: How often:		
Have you ever been physically, sexually, or verbally abused by an intimate partner?	Yes	No

List any additional information you feel is important for us to know____
____

NOTE: I understand that it's important for both the provider and the patient or his/her guardian to talk honestly about the patient's health before treatment starts. I have answered all of the questions above completely and accurately. I understand that the provider(s) and his/her staff need this information, so the patient receives the right kind of care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

The provider and I have talked about any questions I had about this form.
I will not hold the provider, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Patient:____ Date:______________________

FOR COMPLETION BY MEDICAL/DENTAL PROVIDER

Comments: ____

Office Use Only:

[ ] Medical Alert [ ] Premedication [ ] Allergies [ ] Anesthesia

Reviewed by:____ Date: ______________________