Medical Information In-take Form - ADULT

Name: _____ Birth Date: _____

Tobacco Use: (Circle One) Cigarettes Pipe Cigars Chew
Year Started: _____ Year Quit:_____ How much per day: _____
Alcohol Use: (type/amount/frequency)_____

Medical Problems/Significant Hospital Stays	Year	Previous Surgeries	Year
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	

Family Medical History (i.e. heart attack, stroke, diabetes, colon cancer)

Mother: _____ Father: _____

Sibling(s): _____

Other: _____

Medications:

Name	Strength	Directions as noted on bottle
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Allergies to medication	reaction
1.	
2.	
3.	

Exercise type and frequency:

_____

Advanced Directive? (Circle One) Yes or No

Power of Attorney? (Circle One) Yes or No

Most recent …

Pap Smear	Mammogram	Colonoscopy
_____	_____	_____
Dexa Scan	**Tetanus Shot**	**Shingles Shot**
_____	_____	_____
Flu Shot	**Pneumonia Shot**	
_____	_____	