Alsea Clinic Adult Medical and Social History

Today's Date:________________
Name:____________________________
Date of Birth:_________________

Occupation:___________________________
Spouse/Partner's Name:________________
Number of Children:________

Current Medications	Dosage	Frequency

Allergies None ☐	Reaction

Surgeries	Date

Immunization History	Date
Flu	
Pneumonia	
MMR	
Hep A/B	
Shingles	
Tetanus	
Tdap	
TB test	

Previous Regular Healthcare Provider:
Where:

Exam History	Date
Vision	
Colonoscopy	
Bone Density	
Cholesterol	
Pap Smear/HPV	
Breast	
Mammogram	
PSA	
Prostate	
Dental	

You and Your Family Medical History		
Type of Ailment	Self	Family Member
Alcohol Issues		
Drug Use		
Allergies		
Arthritis		
Asthma		
Bleeding/Clotting Disorder		
Cancer		
Diabetes		
Gastrointestinal Problems		
Genitourinary Problems		
Headaches/Migraines		
Heart Problems		
High Cholesterol		
High Blood Pressure		
Kidney Disease		
Mental Illness		
Suicide Attempt		
Musculoskeletal Disorders		
Nervous System Disorders		
Obesity		
Osteoporosis		
Stroke		
Thyroid Disease		

Tobacco Use Never ☐	No. of Years	Quit Date
Cigarettes		
Pipe		
Cigar		
Snuff/Chew		
Comments:		

Alcohol Use Never ☐	No. of Years	Quit Date
Beers per week:		
Glasses of wine per week:		
Shot of liquor per week:		
Comments:		

Drug Use Never ☐	No. of Years	Quit Date
Type of Drugs:		
Comments:		

For Men Only:	Yes	No
Are you currently sexually active?		
Male ☐ Female ☐ Both ☐		
Do you use condoms to protect from STD's?		
Do you self examine your testicles?		
Have you been a victim of physical or sexual abuse?		
Comments:		

Personal Concerns	Yes	No
Have you been in the military?		
Have you had a blood transfusion?		
Do you have a caffeine concern?		
Exposure to occupational hazards?		
Do you have sleep concerns?		
Exposure to hobby hazards?		
Do you have concerns about stress?		
Do you have concerns about weight?		
Do you have a back care concern?		
Do you exercise?		
Do you use a seat belt?		
Comments:		

For Women Only:		
Number of pregnancies:		
Number of births:		
Number of miscarriages:		
Number of abortions:		
Last menstrual period:		
Present type of birth control:		
	Yes	No
Tubal ligation?		
Are your cycles regular?		
History of abnormal pap smears?		
Do you self examine breasts?		
Do you use condoms to protect from STD's?		
Are you sexually active?		
Male ☐ Female ☐ Both ☐		
Have you been a victim of physical or sexual abuse?		
Comments:		