JORDAN VALLEY COMMUNITY HEALTH CENTER Name _____ Date of Birth ____ / ____ / _____

Adult Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

❑ ADD / ADHD	____/____/____	❑ Stroke	____/____/____	❑ Liver disease	____/____/____
❑ Allergies	____/____/____	❑ Cystic fibrosis	____/____/____	❑ Cognitively & Developmentally Disabled	____/____/____
❑ Anemia	____/____/____	❑ Dizziness/Fainting spells	____/____/____		
❑ Chest pain	____/____/____	❑ Emphysema	____/____/____		
❑ Anxiety	____/____/____	❑ Coronary artery disease	____/____/____	❑ Migraine headaches	____/____/____
❑ Arthritis	____/____/____	❑ Crohn's disease	____/____/____	❑ Mitral valve prolapsed	____/____/____
Location: _____		❑ Depression	____/____/____	❑ Heart attack	____/____/____
❑ Artificial heart valve	____/____/____	❑ Diabetes	____/____/____	❑ Stomach ulcer	____/____/____
❑ Asthma	____/____/____	❑ Down's syndrome	____/____/____	❑ Osteoporosis	____/____/____
❑ Atrial fibrillation	____/____/____	❑ Gallbladder disease	____/____/____	❑ Jaw pain	____/____/____
❑ Autism	____/____/____	❑ Heartburn	____/____/____	❑ Kidney disease	____/____/____
❑ Prostate enlargement	____/____/____	❑ Hemophilia	____/____/____	❑ Seizure	____/____/____
❑ Blood clots	____/____/____	❑ Heart murmur	____/____/____	❑ Sinus trouble	____/____/____
❑ Bruise easily / Excessive bleeding	____/____/____	❑ Heart trouble / disease	____/____/____	❑ Spina bifida	____/____/____
❑ Cancer	____/____/____	❑ Hepatitis	____/____/____	❑ Taken Phen-Fen or Redux	____/____/____
Type: _____		Type: _____			
		❑ Herpes	____/____/____	❑ Tuberculosis	____/____/____
❑ Chemotherapy / Radiation Treatment	____/____/____	❑ HIV	____/____/____	❑ Thyroid disease	____/____/____
		❑ High cholesterol	____/____/____	Other:	
❑ Cold sores / Fever blisters	____/____/____	❑ High blood pressure	____/____/____	_____	____/____/____
❑ Convulsions / Epilepsy	____/____/____	❑ Irregular heart beat	____/____/____	_____	____/____/____
❑ Cortisone medicine	____/____/____	❑ Irritable bowel disease	____/____/____	_____	____/____/____

Surgical History

Please check all that apply.

	Date		Date		Date
❑ Angioplasty	_____	❑ Carpal tunnel	_____	❑ Knee replacement	_____
❑ Heart Stent	_____	❑ Cataract	_____	❑ LASIK	_____
❑ Appendix removed	_____	❑ Gallbladder	_____	❑ Liver biopsy	_____
❑ Knee surgery	_____	❑ Gastric bypass	_____	❑ Pacemaker	_____
❑ Back surgery	_____	❑ Hernia repair	_____	❑ Thyroid removed	_____
❑ Heart surgery	_____	❑ Hip replacement	_____	❑ Tonsils removed	_____

Other: _____ _____

Female Surgical History

	Date		Date
❑ Bilateral tubal ligation	_____	❑ D and C (Dilation and curettage)	_____
❑ Breast biopsy	_____	❑ Uterus removed	_____
❑ Cesarean section	_____	❑ Breast removed	_____
		❑ Ovaries removed	_____

Other: _____ _____

Male Surgical History

	Date		Date
❑ Prostate biopsy	_____	❑ Vasectomy	_____
❑ Prostate removal	_____	Other: _____	_____

Gynecologic History

Age of onset of periods _____ ❑ Are you in menopause?

Date of last menstral period ____ /____ /_____ Number of pregnancies _____

Live births _____ Miscarriages _____ Elective Abortions _____

JORDAN VALLEY COMMUNITY HEALTH CENTER Name _____ Date of Birth ____ / ____ / _____

Adult Family History

Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death.

❑ Adopted	Mother	Father	Brother	Sister	Grandparents	Children	Cause of Death
❑ ADD/ADHD							
❑ Alcoholism							
❑ Allergies							
❑ Anxiety							
❑ Alzheimer's disease							
❑ Asthma							
❑ Blood disease							
❑ Heart disease							
❑ Heart disease before age 50							
❑ Cancer							
Type: _____							
❑ Stroke							
❑ Depression							
❑ Developmental delay							
❑ Diabetes							
❑ Eczema							
❑ Hearing loss							
❑ High cholesterol							
❑ Hypertension							
❑ Inflammatory Bowel Disease							
❑ Kidney disease							
❑ Learning disability							
❑ Mental illness							
❑ Migraines							
❑ Obesity							
❑ Osteoporosis							
❑ Peripheral Vascular Disease							
❑ Seizures/epilepsy							
Other: _____							
Other: _____							

Education

Highest Level of Education Competed:

❑ Some High School
❑ High School
❑ Some College
❑ Associate Degree
❑ Bachelor Degree
❑ Advanced Degree
Other: _____

Employment

❑ Full-Time
❑ Retired
❑ Disabled
❑ Part-Time
❑ Student
❑ Unemployed
Other _____
Occupation _____

Marital Status

❑ Single
❑ Married
❑ Divorced
❑ Widowed
Other _____
Children? _____
Sons _____
Daughters _____
Total Number in Household _____

JORDAN VALLEY COMMUNITY HEALTH CENTER Name _____ Date of Birth ____ / ____ / _____

Adult Social History

Do you use tobacco? ❑ Yes ❑ No ❑ Former Type of tobacco used? _____/_____
Packs per day? _____ Years smoked? _____ Year Quit? _____
Do you drink caffeine? ❑ Yes ❑ No Type? _____ Amount Daily? _____
Do you drink alcohol? ❑ Yes ❑ No ❑ Former Year Quit? _____
How much per week? _____ Last Drink? _____

Lifestyle

Activity Level ❑ Sedentary ❑ Moderate ❑ Vigorous

Exercise Frequency ❑ Never ❑ 2-3 times/week ❑ 3-4 times/week ❑ Daily

Type of Exercise _____

Diet History (types tried) _____

Safety

Use seat belts? ❑ Yes ❑ No

Drug Use Abuse

Have you ever used illegal drugs? ❑ Yes ❑ No ❑ Formerly Type _____

Health Maintenance			Approx. Date of last
History and Physcial	❑ Yes	❑ No	____/____/_____
Cholesterol	❑ Yes	❑ No	____/____/_____
PSA	❑ Yes	❑ No	____/____/_____
Colonoscopy	❑ Yes	❑ No	____/____/_____
Stool blood screening	❑ Yes	❑ No	____/____/_____
Flu shot	❑ Yes	❑ No	____/____/_____
Pneumonia shot	❑ Yes	❑ No	____/____/_____
Tetanus shot	❑ Yes	❑ No	____/____/_____
Bone density	❑ Yes	❑ No	____/____/_____
Female exam	❑ Yes	❑ No	____/____/_____
PAP smear	❑ Yes	❑ No	____/____/_____
Mammogram	❑ Yes	❑ No	____/____/_____
Breast exam	❑ Yes	❑ No	____/____/_____

Disease Management			Approx. Date of last
Abdominal Ultrasound	❑ Yes	❑ No	____/____/_____
Stress test	❑ Yes	❑ No	____/____/_____
Chest X-Ray	❑ Yes	❑ No	____/____/_____
Heart Ultrasound	❑ Yes	❑ No	____/____/_____
EKG	❑ Yes	❑ No	____/____/_____
Eye exam	❑ Yes	❑ No	____/____/_____
Foot exam	❑ Yes	❑ No	____/____/_____
Lung Function test	❑ Yes	❑ No	____/____/_____

Advance Directives

Date Reviewed: _____ ❑ None ❑ DNR ❑ Living Will ❑ Durable Power of Attorney ❑ HC Proxy

Medications

Medication ❑ No medications

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Allergies

1.	4.
2.	5.
3.	6.