

Easton Family Practice										1/2	
Adult Medical History											
Name:				Age:				Birthdate:			
Address:				Sex: M		F					
Home Phone:						work:					
Emergency Contact:											
Occupation:						Phone:					
Single		Married		Divorced		Widowed		Separated			
Allergies											
Yes						No					
Medicine & Type of Reaction:											
Past Medical History:											
High Blood Pressure			T.B			Weight Loss			Back Problems		
Heart Disease			Abdominal Pain			Thyroid Disease			Anemia		
Mitral Valve Diseas			Nausea/ Vomiting			Diabetes			Blood Disorders		
Chest Pain			Vomiting Blood			Kidney Disease			Venereal Diseases		
Shortness of Breath			Constipation/Diarrhea			Kidney Stones			Anxiety		
Swollen Ankles			Blood in Stool			Difficulty Urinating			Depression		
Pneumonia			Stomach Ulcers			Frequent Urination			Suicide Attempt		
Bronchitis			Hemorrhoid			Headach			Alcohol Abuse		
Asthma			Gall Bladder Disease			Hay Fever			Gout		
Rheumatic Fever			Hepatitis			Cancer			AIDS		
Persistent Cough			Colitis			Arthritis			Skin Diseases		
Medication (Prescription, Over the Counter, Herbs, Vitamine)											
Drug Name			Dose			Drug Name			Dose		
Hospitalization & Surgery											
Date		Reason				Date		Reason			
Immunization History											
Tetanus		Yes		No		Pneumonia		Yes		No	
Hepatitis B		Yes		No		FLU		Yes		No	
MMR		Yes		No		Other					
Women Only											
Pregnant		Yes		No		Number of: Pregnancy		Abortion			
Planing Pregnancy		Yes		No		Method of Birth Control:					
Age at onset of periods:						Frequency:			Length of period:		
LMP:						Prolonged or Abnormal Bleed:			Yes No		
Last Pap Smear:				Normal		Abnormal					
Last Mammogram:				Normal		Abnormal		Last Breast Exam:			
Sexual Transmitted Diseases				Yes		No					
HPV				Chlamydia		Gonorrhea		Syphilis			

Men Only							2/2	
Prostate Problem:	Yes	No						
Date Last PSA:	Result:		Normal	Abnorma				
Last Prostate Exam:	Result:		Normal	Abnorma				
Erection Difficulty:	Yes	No	Penis Discharge:	Yes	No			
Sexual Transmitted Disease:	Yes	No	Explain:					
Habits								
Smoking	Yes	No	Packs Daily:	How Long:				
	Interested in Stopping:		Yes	No				
Alcohol	Yes	No	Type	Amount:	How Long:			
Drug	Yes	No	Type	Amount:	How Long:			
Coffe	Yes	No	How Many:	Other:				
Exercise	Yes	No	How long:					
Seat Belt	Yes	No		Gun at Home	yes	No		
Condoms	Yes	No		Living Will	yes	No		
Are You a Victim of:			Phsical Abuse	Yes	No			
			Sexual Abuse	Yes	No			
			Neglect	Yes	No			
Family History								
		Father	Mother	Children	Siblings	GF	GM	
Alcoholism								
Asthma								
Bleeding Disorder								
Cancer								
Diabetes								
Epilepsy								
Glaucoma								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Migraine								
Osteoporosis								
Stroke								
Thyroid Disease								
Other								
Preventive Care								
		Normal	Abnormal	Date		Normal	Abnormal	Date
Rectal/ Stool:					Cholesterol:			
Colonoscopy:					T.B			
Other:								
I certify that the above information is correct (page 1 & 2) to the best of my knowledge. I will not Hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.								
Patient/ Guardian Signature				Date				
Reviewed by				Date				

