

CROSS TRAILS MEDICAL CENTER
PATIENT HISTORY
ADULT / GERIATRIC LIFECYCLE
(Ages 20+ years)

Date Completed: ____/____/____

PLEASE FILL IN ALL INFORMATION AS COMPLETE AS POSSIBLE.

NAME: _____ **DATE OF BIRTH:** ____/____/____

Current Medications: _____

Allergies: _____

PAST MEDICAL HISTORY:

Previous Surgeries: _____

Previous Illnesses: _____

Previous Hospitalizations: _____

SOCIAL HISTORY:

Marital Status (circle appropriate response): Single Married Widowed Separated Divorced

Live alone: Yes / No

Occupation: _____ Retired or Disabled

Children: # of daughters _____ # of sons _____

Use of tobacco: (circle appropriate response) Never Previously, but quit: _____ Current, packs per day _____

Use of alcohol: (circle appropriate response) Never Rarely Moderately Daily

Use of drugs: (circle appropriate response) Never Type / frequency: _____

Excessive exposure at home or work to: Fumes Dust Solvents Airborne particles Noise

FAMILY HISTORY: (Check if you know there is family history of the following)

	PARENTS		GRANDPARENTS		SIBLINGS	
	Father	Mother	Fraternal	Maternal	Brother	Sister
Heart Disease						
Heart Attack						
Stroke						
Hypertension						
Diabetes Mellitus						
Breast Cancer						
Ovarian Cancer						
Colon Cancer						
Other:						

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REVIEW OF SYSTEMS: (CIRCLE "YES" or "NO" AS APPROPRIATE)

HEENT

Frequent Headaches Yes / No
Hearing Problems Yes / No
Vision Problems Yes / No
Glaucoma Yes / No
Cataracts Yes / No
Allergy Symptoms Yes / No
Ear Infections Yes / No

MUSCULOSKELETAL

Joint Pain Yes / No
Arthritis Yes / No
Gout Yes / No
Back Problems Yes / No
Sports Injury Yes / No

ENDOCRINE

Diabetes Yes / No
Goiter Yes / No
Thyroid Problems Yes / No

HEMATOLOGIC / IMMUNOLOGIC

Anemia Yes / No
Sickle Cell Trait / Anemia Yes / No
Bleeding Disorder Yes / No
Cancer Yes / No

GENITOURINARY / GYNECOLOGICAL

Urinary Tract Infections Yes / No
Kidney Problems Yes / No
Kidney Stones Yes / No
Loss of Bladder Control Yes / No
Breast Lumps Yes / No
Sexually Transmitted Diseases Yes / No
HIV / AIDS Yes / No
Venereal Warts / Lesions Yes / No

MALE

Prostate Problems Yes / No
Difficulty with Erection Yes / No
Lump in Testicles Yes / No
Discharge at Penis Yes / No

Date of:

Last Rectal Exam _____

Last PSA _____

Last Testicular Exam _____

Hernia Exam _____

PREVENTION

Exercise Plan Yes / No
Monitor Dietary Fat Yes / No
Use Seat Belts Yes / No
Last Pneumonia Vaccine _____
Last Tetanus Vaccine _____
Last Flu Vaccine _____
Last Dental Visit _____
Last Vision Exam _____

**ACTIVITIES OF DAILY LIVING
(FOR PATIENTS OVER AGE 65)**

Can you get out of bed yourself Yes / No
Can you dress yourself Yes / No
Can you do your own shopping Yes / No

RESPIRATORY

Asthma Yes / No
Bronchitis Yes / No
Pneumonia Yes / No
Emphysema Yes / No
Tuberculosis Yes / No
Date of last PPD (tuberculosis skin test) _____

PSYCHOLOGICAL

Anxiety Yes / No
Depression Yes / No
Suicide Yes / No
Psychiatric Counseling Yes / No
Alcoholism Yes / No
Drug Abuse _____

SKIN

Itching Yes / No
Eczema Yes / No
Psoriasis Yes / No
Sores that won't heal Yes / No
Changes in Moles Yes / No
Skin Cancer Yes / No
Excessive Sun Exposure Yes / No

GASTROINTESTINAL

Liver Disease Yes / No
Hepatitis Yes / No
Gallbladder Problems Yes / No
Ulcers Yes / No
Indigestion Yes / No
Abdominal Pain Yes / No
Blood in Bowel Movements Yes / No
Hemorrhoids Yes / No
Poor / Change in Appetite Yes / No
Undesired Weight Gain / Loss Yes / No
Constipation Yes / No
Diarrhea Yes / No

FEMALE

Are you pregnant Yes / No
Vaginal Discharge / Lesions Yes / No
Pelvic Infections Yes / No
Irregular Periods Yes / No
Extreme Menstrual Pain Yes / No
Painful Intercourse Yes / No
Hot flashes Yes / No
Hormonal Replacement Yes / No
Abnormal PAP smear Yes / No
Abnormal Mammogram Yes / No

Date of:

Last Menstrual Period _____

Last PAP smear _____

Last Mammogram _____

Type of contraception _____

Number of living children _____

Number of pregnancies _____

To assess the risk factor for cervical cancer:

Age of first intercourse _____

Number of sexual partners:

In your lifetime _____

Currently _____