

ADULT MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL- PLEASE COMPLETE ALL ITEMS ON THIS PAGE

Name _____ Birthdate _____ - _____ - _____

CURRENT MEDICAL PROBLEMS	MEDICATIONS	ALLERGIES

HOSPITALIZATIONS (Most Recent)	DATE	SURGERIES	DATE

MOST RECENT DATES OF (MONTH AND YEAR)

- a) Tetanus shot _____
- b) Physical exam _____
- c) Pap smear _____
- d) Mammogram _____
- e) Pneumonia shot _____

FAMILY HISTORY: Check disease(s) in your family and indicate which family member(s) is affected by the disease

a. Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____	b. Hypertension <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____	c. Stroke <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____
d. Cancer Breast <input type="checkbox"/> yes <input type="checkbox"/> no Colon <input type="checkbox"/> yes <input type="checkbox"/> no Prostate <input type="checkbox"/> yes <input type="checkbox"/> no Other Site <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____	e. Heart Disease <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____ _____	f. Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____ _____
g. Mental/Emotional Problems <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____	h. Alcoholism <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____	I. Lung Disease <input type="checkbox"/> yes <input type="checkbox"/> no Family Members _____

SOCIAL HISTORY:

Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No _____ packs per day	Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No _____ drinks per day	Sexually active <input type="checkbox"/> Yes <input type="checkbox"/> No
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MEN ONLY

Have you had prostate trouble? **NO** **YES**

WOMEN ONLY

Age menstrual periods began _____

Date of last menstrual period _____

Have you ever:

- Been pregnant # of times _____
- Had a miscarriage # of times _____
- Had an abortion # of times _____
- Had complications of pregnancy explain _____
- Do you use birth control what kind? _____
- Do you do monthly self breast exams?

DO YOU HAVE A LIVING WILL?

THIS SIDE IS TO BE COMPLETED BY CLINICAL OR PROVIDER STAFF

PSYCHOSOCIAL ASSESSMENT

Emotional Status: Anxious Sad Confident
 Marital Status: Married Widowed Divorced/Separated Single
 Occupation: Retired Employed Unemployed Disabled
 Lives With: Self Spouse Family Nursing Home
 Other Name: _____
 Activities of daily living performed by: Self Family w/Assistant _____
 Activity Level: Can walk alone Wheelchair Cane Walker Bed rest
 Current Use of Medical Equipment in the Home: Yes No List _____

CURRENT FUNCTIONAL ABILITY	SELF	ASSISTED BY
Bathing, Dressing, Eating		
Dressing		
Toileting		
Driving		
Managing Medicine		
Cooking/Housework		
Walking		

NUTRITION ASSESSMENT

Time for Breakfast _____
 Lunch _____
 Supper _____
 Food intolerances _____
 Unplanned Weight Loss (with in last month) Yes how much? _____ No
 50% Reduction of food intake for 5-7 days Yes No
 Difficulty Chewing/Swallowing Yes No
 Do you have/need dentures Yes No
 Nausea/Vomiting Yes No
 Diarrhea/Constipation Yes No

EDUCATIONAL ASSESSMENT

Education (years of formal education completed) _____
 Any difficulty talking or speaking Yes _____ No
 Physical Disability/Impairments Yes _____ No
 Language: English Other _____ Interpreter _____ No
 Emotional Barriers: (i.e. fear, anxiety) Yes _____ No
 Can You Read? Yes No
 Motivated to learn/Readiness Level Yes No
 Culture/Religious practices which may impact learning: Yes No
 Other: _____
 Learner learns best by: Verbal Instruction Audiovisual Instruction Written Instruction All

PERCEIVED EDUCATIONAL NEEDS: Do you or your family need information on the following?
 Diagnosis/Illness Medications Diet Activity Equipment Home Care Community Resource

REVIEWED BY: _____ **DATE COMPLETED:** _____