Adult Patient's Check List for Medical History **Today's Date: _____**

Name: _____ DOB: _____ Program/ Grad Year: _____

Current medical problems or treatments (please include name and city of Healthcare providers)

_____

_____

_____

Current Medications:

_____

_____

Drug Allergies:

_____

_____

Past Surgeries:

_____

_____

Hospitalization:

_____

_____

Past medical History:

_____

_____

History of sexually transmitted diseases:

_____

_____

Family Health History:

_____

_____

Travel History outside of the US in past 2 years:

_____

_____

Living will/ durable power of attorney? Yes No

Symptoms within the past 3 months:

Y	N	Severe headaches	Y	N	Trouble with balance	Y	N	Muscle pain
Y	N	Dizzy spells	Y	N	Shaking/ tremors	Y	N	Swollen Joints
Y	N	Shortness of Breath	Y	N	Back pain	Y	N	Swelling of ankles
Y	N	Wheezing	Y	N	Paralysis	Y	N	Chronic nose obstruction
Y	N	Eye pain	Y	N	Chronic abdominal Pain	Y	N	Disturbance in walking
Y	N	Fall	Y	N	Severe Hearing Loss	Y	N	Frequent urination
Y	N	Chest pain	Y	N	Speech disturbances	Y	N	Retention of urine
Y	N	Hypertension	Y	N	Wear glasses	Y	N	Painful menstruation
Y	N	Heartburn	Y	N	Failing vision	Y	N	Passing stones (urine)
Y	N	Strokes	Y	N	Repeated nosebleeds	Y	N	Urinary hesitation
Y	N	Varicose vein	Y	N	Discharge from ears	Y	N	Blood in urine
Y	N	Night sweats	Y	N	Pain in ears	Y	N	Leakage of Urine
Y	N	Chronic cough	Y	N	Ringing in ears	Y	N	Vaginal Discharge
Y	N	Loss of appetite	Y	N	Persistent sore gums	Y	N	Pain with urination
Y	N	Seizures	Y	N	Prolonged hoarseness	Y	N	Weak urine stream
Y	N	Frequent colds	Y	N	Irregular heartbeat	Y	N	Bleeds between periods
Y	N	Sinus or hay fever	Y	N	Difficulty breathing	Y	N	Missed menstrual cycle
Y	N	Sexual Problem	Y	N	Cough blood	Y	N	Excess menstruation
Y	N	Excessive Fear	Y	N	Persistent nausea	Y	N	Hemorrhoids
Y	N	Depression	Y	N	Vomit blood	Y	N	Blood in rectum
Y	N	Anxiety	Y	N	Limiter range of motion	Y	N	Clay colored stool
Y	N	Shoulder Pain	Y	N	Sensation of numbness	Y	N	Black tarry stool
Y	N	Joint pain	Y	N	Chronic Diarrhea	Y	N	Habitual constipation

Current Smoker? Yes No History Of Smoking? Yes No Illicit Drug Use? Yes No

How often do you drink alcohol and how much per occasion? _____

Do you eat a balanced diet? _____

Do you have a lot of stress? _____

Do you exercise regularly? _____

Additional Health Issues: _____