



DEMERA

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ADULT MEDICAL HISTORY

Patient Name _____ DOB _____ Date _____

Age _____ Sex _____ Ht _____ Wt _____ BMI _____

Primary Physician _____ Referring Physician _____

Reason for Visit _____

Medical History (check box if applicable and explain):

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Cancer (list types & dates) | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Neurologic Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice / Hepatitis | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Reflux | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Attack | (TB, Asthma, Pneumonia, CF) | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Other (explain) |
| <input type="checkbox"/> High Blood Pressure` | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke | |

Surgical History: _____

Current Medications/Dosage: _____

Allergies/Intolerances to Medications: _____

Family History (reference family member):

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Attack _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Hives _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Stroke _____ |

Social History: Birthplace: _____ How long in local area _____

Smoking? YES / NO Years smoked _____ Packs per day _____ Year quit _____
 Alcohol? YES / NO Number of years _____ Amount daily or weekly _____
 Occupation: _____ Number of children _____ Marital Status: S M D W

Review of System (check box if applicable recently):

- General:** Fever Weight Loss Loss of appetite Fatigue
- Eyes:** Visual impairment Cataracts Glaucoma Double vision Eye Injury
- ENT:** Dizziness Canker sores Hearing loss Ringing in the ears Loss of Smell Loss of Taste
- CV:** Irregular beat Palpitations Chest pains (angina) Foot/ankle swelling
 Leg pain Poor circulation in legs Varicose veins
- Resp:** Wheezing Cough Cough w/mucous or w/o shortness of breath Recurrent infections
- GI:** Heartburn/GERD Ulcer Black stools Rectal bleeding Diarrhea Constipation Pain
- GU:** Blood in urine Nausea/vomiting Recurrent infections Urinary tract problems
 Menstrual problems Menopause Prostate trouble
- MS:** Joint pain Autoimmune disease (lupus, etc.)
- Neuro:** Headaches Seizure disorder Brain injury Developmentally disabled/ Learning disability Fainting spells
- Integument:** Eczema Psoriasis Boils Acne Chronic Rashes
- Endocrine:** Polydipsia (always thirsty) Polyuria (frequent urination) Cold Hot Tremors
- Heme/Lymph:** Anemia Bleeding Disorder