FIU HEALTH
FACULTY GROUP PRACTICE

Medical History Form - Adolescent and Adult

Name *(Last, First, M.I.)*: ☐ M ☐ F		**DOB:**
Age:	**Previous or referring doctor**:	**Date of last physical exam:**

Which of the following conditions are you being treated for or have been treated for in the past? (Check all that Apply)					
✓		✓		✓	
	Acne		Headache/Migraines		Sexually Transmitted Infection
	Anemia or bleeding problems		Heartburn/Reflux		Sinus Problems
	Arthritis		Heart Disease/Murmur/Angina		Stroke
	Asthma		High Blood Pressure		Swollen Ankles
	Blood Clots		High Cholesterol		Ulcers/Colitis/Gastritis
	Blood in Stools		Kidney/Bladder Problems		Tonsillitis
	Breast Mass/Cyst		Liver Problems/Hepatitis		Tuberculosis
	Cancer		Lung Problems/Cough/COPD		None of the Above
	Depression/Anxiety		Neurological Problems		Other Medical Problems:
	Diabetes		Osteoporosis/Osteopenia		
	Ear/Hearing Problems		Psychiatric Care		
	Eating Disorder		Seasonal Allergies		
	Eye/Vision Disorder		Seizures		

Allergies and specific reactions

1. ☐ No known allergies
2. ☐ Aspirin
3. ☐ Penicillin
4. ☐ Sulfa
5. ☐ Codeine
6. ☐ Other drugs (please list) ____________________________
7. ☐ Food(specify)__________
8. ☐ Other ________________

List your prescribed medications and over-the-counter drugs, such as vitamins and inhalers		
Name the Medication	**Strength**	**Frequency Taken**

List past surgeries	**Year**

Patient Name: ______________________________
DOB: ____________________
8/8/13

List past hospitalizations	Year

Family History			
Relationship	**Living**	**Age (or age at death)**	**List serious illness(es)**
Mother	□ Yes □ No		
Father	□ Yes □ No		
Sisters	□ Yes □ No		
	□ Yes □ No		
Brothers	□ Yes □ No		
	□ Yes □ No		

Social and Health Behaviors			
1.	Do you currently smoke or chew tobacco?		□ Yes □ No
		If no, have you in the past?	□ Yes □ No
		If you've smoked or chewed tobacco in the past or currently do:	How many per day? ____ packs ____ cigars ____ eCigarettes For how long? ____ years If former, when did you quit? ______
2.	Do you sometimes drink alcohol, beer or wine?		□ Yes □ No
		If yes, how often?	____ drinks per week
		If yes, what kind?	□ Alcohol □ Beer □ Wine □ Other
3.	Do you drink caffeine?		□ Yes □ No
		If yes, how many cups per day?	_____cups
4.	Do you wear a helmet when riding a bike?		□ Yes □ No
5.	Do you use seat belts while driving?		□ Yes □ No
6.	Do you use non-prescription or over the counter drugs?		□ Yes □ No
		If yes, what kind?	
7.	Do you exercise?		□ Yes □ No
		If yes, how often?	_____ times/week
		If yes, what type of exercise?	
8.	When was your last visit to the dentist?		
9.	Do you live alone?		□ Yes □ No
		If no, with whom?	
10.	Do you use any assistive equipment (i.e. cane, walker)?		□ Yes □ No
		If yes, what equipment?	□ Cane □ Wheelchair □ Walker □ Other
11.	Has a fight between you or your partner ever gotten so bad that one of you got hurt, kicked, hit or punched?		□ Yes □ No
12.	Have you ever had a colonoscopy or sigmoidoscopy to screen for colon cancer?		□ Yes □ No
		If yes, what test:	□ Colonoscopy □ Sigmoidoscopy

		If yes, when was your last test?	
		If yes, what were the results:	
13.	Have you ever had a bone density test?		□ Yes □ No
		If yes, when was your last test?	
		If yes, what were the results:	
14.	Have you ever had the Tetanus Vaccine?		□ Yes □ No
		If yes, when was your last vaccine?	
15.	Have you had the Flu vaccine?		□ Yes □ No
		If yes, when was your last vaccine?	
16.	Have you had a Pneumonia vaccine?		□ Yes □ No
17.	Have you had a Shingles vaccine?		□ Yes □ No
FOR WOMEN ONLY:			
18.	Menstrual History:		□ Not applicable
		Age at onset:	_____ years
		Regular	□ Yes □ No
		Cycle	____days
		Duration	____days
		Pains or cramps	□ Yes □ No
		Flow	□ Light □ Moderate □ Heavy
19.	How many times have you been pregnant?		
20.	Date of last Pap Smear:		
		Have you had abnormal Pap Smears?	□ Yes □ No
		If yes, diagnosis:	
		If yes, follow up:	
21.	Date of last mammogram:		
		Mammogram results:	
		Have you ever had a breast biopsy?	□ Yes □ No
		If yes, breast biopsy - biopsy results:	
FOR MEN ONLY:			
22.	Do you perform regular testicular exams?		□ Yes □ No
FOR STUDENTS AGED 13-18 ONLY:			
23.	Student Status:		□ Full Time □ Part Time
		Name of School	
		Grade	
24.	Do you play sports?		□ Yes □ No
		If yes, specify	

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Patient Name: ____

Patient Signature: ______________________________________ Date: __________________

For completion when other than the patient signing or when a minor,

I _________________________am the parent, legal guardian, custodian or have Power of Attorney for this patient, for purpose of treatment, payment or health care operations.
Signature of Parent/ Legal Guardian/Custodian/Individual with Power of Attorney : _________________________

Printed Name of Signer: ___________________________ Relationship to Patient: ___________________________

Date: ____________