LILLINGTON FAMILY MEDICAL CENTER
ADULT PAST MEDICAL HISTORY

PAST MEDICAL HISTORY

Pharmacy: _____

Chronic Medical Problems: _____

_____

Current Medications: _____

_____

Drug Allergies: _____

Hospitalizations or Surgeries: _____

_____

Please List Any Specialty Providers You May See: _____

_____

Vaccines: (*when was your last…?)*
Tetanus: _____

Flu: _____

Pneumonia: _____

Zostavax: _____

Gardasil (HPV): _____

Menactra (Meningitis): _____

Preventative Procedures: *(when was your last… and where…?)*
Physical Exam: _____

Colonoscopy: _____

Mammogram: _____

Pap Smear: _____

Dexa (Bone Density): _____

Eye Exam: _____

SOCIAL HISTORY

Marital Status: □Married □Single □Separated □Divorced □Widowed

Occupation: _____ Spouse's Name: _____

Number of Children: _____ Level of Education: □High School □GED □College _____

Tobacco Use: □Y □N □smoke □dip/chew How much? _____	Illicit Drug Use: □Y □N What kind? _____	Alcohol Use: □Y □N How much? _____

FAMILY HISTORY			*If yes, how is family member related to you, age diagnosed/at death, etc.*
Diabetes	Y	N	
Thyroid Disorder	Y	N	
Lung Disease □*COPD* □*Emphysema* □*Asthma*	Y	N	
Cancer *(what type?)*	Y	N	
Heart Disease	Y	N	
High Blood Pressure	Y	N	
Stroke	Y	N	
Kidney/Urinary Disease	Y	N	
Liver Disease	Y	N	
Gastrointestinal Disease	Y	N	
Alcoholism/Substance Abuse	Y	N	
Mental/Nervous Disorder	Y	N	

Please list any other medical conditions that run in your family: _____

_____

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_____