Martha Jefferson Medical Group
SENTARA

ADULT
COMPREHENSIVE HEALTH HISTORY

Patient Name:	Patient Date of Birth:
Form completed by:	Date Completed:

PAST MEDICAL HISTORY *(include year if known)*

☐ Asthma	☐ Heart Attack	☐ Stroke
☐ Back Problems	☐ Hepatitis A, B, or C	☐ Tuberculosis
☐ Bleeding Problems	☐ High Blood Pressure	☐ Thyroid Disease
☐ Blood Clots	☐ High Cholesterol	☐ Ulcers
☐ Cancer (type)	☐ Infectious Disease (type)	☐ Other:
☐ COPD	☐ Kidney Stones	☐ Other:
☐ Depression	☐ Memory Disorder	☐ Other:
☐ Diabetes	☐ Migraines	☐ Other:
☐ Drug Dependence	☐ Seizure	☐ Other:
☐ Heart Disease	☐ Sleep Apnea	☐ Other:

SURGERIES *(include year if known)*

☐ Appendectomy	☐ Hysterectomy	☐ Other:
☐ Gallbladder (Cholecystectomy)	☐ Other:	☐ Other:
☐ Colonoscopy	☐ Other:	☐ Other:

OTHER PROVIDERS

Do you see any other medical providers? ☐ Yes ☐ No

If so, please list: _____

_____

CURRENT MEDICATIONS/VITAMINS/HERBS/SUPPLEMENTS *(please bring all medications with you)*

Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency

ALLERGIES

Allergies to Medications	☐ Latex	Environmental/Seasonal Allergies

What is your preferred local pharmacy? _____

What is your preferred mail order pharmacy? _____

SUBSTANCE HISTORY

Smoking Status: ☐ Never Smoked
☐ Current Every Day Smoker:
☐ Current Some Day Smoker
☐ Former Smoker – Quit Date: _____ How many years did you smoke? _____
☐ Second Hand Smoke Exposure, but Never Smoked

Type of tobacco:
☐ Cigarettes ☐ Pipe ☐ Cigars _____packs/day Start Date: _____

Smokeless Tobacco: ☐Never Used ☐ Current User ☐ Former User -- Quit Date: _____ **Type:** ☐Snuff ☐Chew

Alcohol Use: ☐ Yes ☐ No **Drinks per Week:** _____ Cans of Beer _____ Shots of liquor _____Glasses of wine

Recreational Drugs: ☐ No ☐ Yes, what substance? _____ Use Per Week: _____

Patient Name:	Date of Birth:

FAMILY HISTORY

Relationship	Name	Alive/ Deceased	No Known Problems	Asthma	Cancer	Cancer, Breast	Cancer, Colon	Cancer, Prostate	Colon Polyp	Dementia	Diabetes	High Cholesterol	Heart Disease	High Blood Pressure	Osteoporosis	Thyroid Disease
Father																
Mother																
Sister																
Brother																
Maternal Aunt																
Paternal Aunt																
Maternal Uncle																
Paternal Uncle																
Maternal Grandmother																
Paternal Grandmother																
Maternal Grandfather																
Paternal Grandfather																
Other:																
Other:																

Additional Family History:

SOCIAL HISTORY

Sexually Active: ☐ Yes ☐ No ☐ Not Currently

Birth Control/Protection (Please Circle): Condoms Pill Diaphragm IUD Surgical Spermicide Implant Rhythm Injection Sponge Inserts Abstinence Patch Vasectomy

Sexual Preference: ☐ Female ☐ Male

OB/GYN History:

Currently Pregnant? ☐ Yes ☐ No Date of Last Menstrual Period: _____ ☐ Unknown

Breast Feeding? ☐ Yes ☐ No

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Single ☐ Unknown ☐Widowed

Spouse Name: _____ **Number of Children:** _____

Is there anything about your medical or personal history that you would like your health care provider to know?

Reviewed by: _____**Date:** _____