

Adult History

Name: _____ D.O.B.: _____ Sex: M/F

Address: _____ Phone: _____

In emergency, notify: _____ Phone: _____

Allergies/Adverse Reactions: None

Current Medications: None

Social History:

Tobacco Usage: None Current use PPD: _____ Prior use Year quit: _____

Alcohol Usage: None Occasional/Rarely Weekly Daily

Drug Usage: None Occasional/Rarely Weekly Daily

Non-prescription medications (vitamins, antacids, pain meds): _____

Family History:

Relation	Age	Health Status	If deceased: Cause/age
Father			
Mother			
Siblings			
Children			

Past Medical/Surgical History:

Hospitalizations:

Date: _____

Date: _____

Date: _____

Surgeries:

Date: _____

Date: _____

Date: _____

Date: _____

Medical Illnesses:

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Immunizations:

Flu: _____

Pneumovax: _____

Td: _____

MMR: _____

Hep B: _____

Other: _____

Signature: _____

Date: _____