Cogdell Family Clinic

Adult Health History

Today's Date: _____

Patient's Full Name: _____

Date of Birth: _____

Allergies: None: _____ Yes ____ List: _____

Current Medications:

Medication / Supplement	Date Started	Dose	Frequency

Current or Past Medical Problems: please circle all that apply

Heart Problems Heart Murmur Asthma Obesity Head Injury

Diabetes Cancer: What type: _____

Broken Bones Lung Disease Other:_____

Surgeries: please circle all that apply:

Tonsillectomy/Adenoidectomy Gallbladder Appendectomy Hysterectomy

Other: _____

Do you drink soft drinks? No Yes how many? _____ How Often? _____

Do you Smoke: No Yes how many? _____ How Often? _____

Do you Drink alcohol? No Yes How much? _____ How Often? _____

Do you use recreational Drugs? No Yes What? _____ How Much/Often?_____

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Do your Parents, Grandparents or siblings have: please check all that apply

	Mother	Father	Siblings B-Brother S-Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer							
High Blood Pressure							
Heart Disease							
Leukemia							
Diabetes							

When was your vision last checked? _____

When was your last dental visit? _____

What is the reason for your visit today? _____

_____

Have you ever had – or when did you have:

Colonoscopy No ___ Yes - ____ When? _____

EGD No ___ Yes - ____ When? _____

Mammogram (Women) No ___ Yes - ____ When? _____

PSA (Men) No ___ Yes - ____ When? _____

Flu No ___ Yes - ____ When? _____

Pneumonia Vaccination No ___ Yes - ____ When? _____

Tetanus Vaccination No ___ Yes - ____ When? _____

Other relevant medical history or concerns you would like to discuss: