ADULT MEDICAL HISTORY INFORMATION

Name:		**Date:**	
Sex:	**Date of Birth:**	**Age:**	**Height:**
Known Drug Allergies:			
Current Medications: None	**Complete Med Sheet**	**Birth Control Method:**	
Date Last Pap Smear:		**Date Last Mammogram:**	
Last Menstrual Cycle:		**Number of Pregnancies:**	
Previous Doctors:		**Surgeries:**	
Bone Density: Yes No	**Colonoscopy : Yes No**	**Date:**	**Doctor:**
Do You Smoke?	**# Cigarettes Per Day:**	**Age Started Smoking:**	
Drink Alcohol?	**# Drinks Per Day:**	**Week:**	
Use Other Drugs?	**How Often?**		
Exercise?	**How Often?**	**Type Of Diet:**	

Please explain (in detail) the reason you are here to see Dr. Schettler:

PERSONAL MEDICAL HISTORY:

Do you have or have you ever had chronic Problems with:	**Yes**	**No**		**Yes**	**No**
			Diabetes		
Female Organs			**High Blood Pressure**		
Menstruation			**Eyes/Ears/Nose/Throat**		
Breast			**Headaches**		
Sexually Transmitted Diseases			**Respiratory**		
Urinary Problems			**Gastrointestinal (abdomen)**		
Blood Disorders			**Skin**		
Immune Deficiency Disorders			**Emotional Illness/Problem**		

If you answered yes to any of the above, please explain:

TB SCREENING: (Please write Y or N):
Do you or have you ever had TB? _____ Anyone in your immediate family have TB? _____
Do you have any of the following?
Cough (> 2 wks) _____ Bloody Sputum _____ Night Sweats _____ Weight Loss _____ Lack of Appetite _____ Fever _____

FAMILY HISTORY: Please mark with appropriate initial(s) (Please list changes since your last visit)
Mother (M) Father (F) Brother (B) Sister (S)
Maternal Grandmother/father (MGM, MGF) Paternal Grandmother/father (PGM,PGF)

Cancer:	**Diabetes:**
Breast:	**Seizures:**
Prostate:	**Mental Illness:**
Other:	**Asthma:**
Heart Disease:	**HIV:**
Heart Attack:	**Blood Diseases:**
High Blood Pressure:	**Osteoporosis:**
Strokes:	