MountainStar
Millcreek Primary Care

_____ _____
Name *Date*

St. Mark's Millcreek Primary Care
Adult Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. **Thank You.**

Date of Birth: _____ How would you rate your general health? □ Excellent □ Good □ Fair □ Poor

Main reason for today's visit: _____
Other concerns: _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement	Dose/Strength (e.g., mg/pill)	How many times per day

ALLERGIES: Do you have allergies or reactions to:

Medications	**Reaction**	**Foods**	**Reaction**
_____		_____	
_____		_____	
_____		_____	

MEDICAL HISTORY: **SURGICAL HISTORY:**

Major Illnesses: (i.e. high blood pressure, high cholesterol, depression, etc.)	Year of Diagnosis	Currently Treated?	Surgeries:	Year of Surgery	Reason for Surgery
1			1		
2			2		
3			3		
4			4		
5			5		

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____
Cancer, specify type _____
Heart disease _____
Depression/suicide _____
Genetic disorders _____
Diabetes _____
Kidney disease _____
High cholesterol _____
High blood pressure _____
Stroke _____
Bleeding/clotting disorder _____
Asthma/COPD _____
Anxiety _____
Other: _____

Women's Health:
Pregnancies: _____
Deliveries: _____
Abortions: _____
Miscarriages: _____
Age at start of periods: _____ Age at end of periods: _____
Last Menstrual Cycle: _____
Last Pap Smear: _____

Immunizations: (Approximate dates are fine)
Date of your last flu shot: _____
Date of your last pneumonia shot: _____
Date of your last tetanus shot: _____

Health Maintenance:
Date of your last physical: _____
Date of your last colonoscopy: _____

SOCIAL HISTORY:

Tobacco Use

Cigarettes □ Never □ Quit Date _____
□ Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ Yes □ No

Alcohol Use

Do you drink alcohol? □ Yes □ No # drinks/week _____
Is your alcohol use a concern for you or others? □ Yes □ No

Drug Use

Do you use any recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No