

ADULT DATABASE

NAME: _____

DOB: ____/____/____

PHARMACY: _____

MEDICINES YOU ARE ALLERGIC TO:

PAST SURGERIES AND DATES:

Appendectomy _____ Cholecystectomy _____ C-section _____ Cataract _____

Hernia _____ Tonsillectomy _____ Hysterectomy _____ Heart Surgery _____

Others (please list) _____

of Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____ C-Sections _____

CHRONIC MEDICAL CONDITIONS:

CURRENT MEDICATIONS:

SOCIAL HISTORY:

Marital status: Single Married Divorced Widowed

Do you drink alcohol? No Yes If yes, how often? _____

Do you smoke? No Yes

Cigarettes? No Yes If yes, how many packs per day? _____ How many years? _____

If quit, when? _____ How long did you smoke? _____ packs per day? _____

Have you ever used illegal drugs? No Yes If yes, did you use IV drugs? No Yes

Have you ever received a blood transfusion or blood product? No Yes If yes, when? _____

FAMILY HISTORY:

| | Living Age: | Deceased Age: | Illnesses: |
|-----------|-------------|---------------|------------|
| Mother: | _____ | _____ | _____ |
| Father: | _____ | _____ | _____ |
| Brothers: | _____ | _____ | _____ |
| Sisters: | _____ | _____ | _____ |

Has any blood relative had: (check and give relationship, use N/A if not applicable)

Stroke _____ Epilepsy _____ Heart attack _____ Nervous breakdown _____

Cancer _____ Diabetes _____ Stomach ulcer _____ Hypertension _____

Migraine _____ Asthma _____ Kidney disease _____ Leukemia _____ Arthritis _____

GIVE THE DATE OF YOUR LAST:

1.) Pap smear: _____
2.) Mammogram: _____
3.) Bone Density: _____
4.) Colonoscopy: _____

5.) Pneumonia Vaccine: _____
6.) Flu Shot: _____
7.) Tetanus Shot: _____
8.) Physical Exam: _____