Wayne Memorial Community Health Centers
Adult Health History

NAME: _____ BIRTHDATE: _____

MEDICAL HISTORY:
1. DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?(INDICATE YES OR NO)

2.LIST ALL ALLERGIES & REACTIONS

High Blood Pressure	Y N	Poor Circulation	Y N	Cancer	Y N	GI Disease	Y N
Heart Disease	Y N	Eye Disease	Y N	Diabetes	Y N	Seizures	Y N
Lung Disease	Y N	Kidney Disease	Y N	Arthritis	Y N	Eating Disorder	Y N
Depression	Y N	Sleep Disorder	Y N				

Other Conditions: _____
_____
Allergies & Reactions:_____
_____

FAMILY HISTORY:

Please list any immediate family members that had a medical illness such as Cancer, Heart Disease, Lung Disease, Diabetes, High Blood Pressure, Depression, Alcohol or Substance Abuse (Example: Mother- Lung Cancer)
_____
_____

SURGICAL HISTORY:

Surgeries: Y N (describe surgery and date)_____
_____
Hospitalization (describe) _____
_____

HOSPITALIZATION HISTORY:

HEALTH MAINTENANCE:

TEST HISTORY:

Date of last Vision screening _____ Date of last Physical exam _____
Date of last Dental exam _____ Date of last Podiatry/Foot exam _____
Have you had any of the following tests? Check each that apply and enter date & result of most recent test
Lipid (Cholesterol) Test ___ Date: _____ Abnormal? Y or N
Sigmoidoscopy/Colonoscopy ___ Date: _____ Abnormal? Y or N
Stool for Occult Blood ___ Date: _____ Abnormal? Y or N
Men
PSA (Prostate) ___ Date: _____ Abnormal? Y or N
Women
Mammogram ___ Date: _____ Abnormal? Y or N
Clinical Breast Exam ___ Date: _____ Abnormal? Y or N
Pap Smear ___ Date: _____ Abnormal? Y or N
Dexa Scan ___ Date: _____ Abnormal? Y or N
If Post Menopause or over 50, do you take: Calcium Y or N Estrogen Y or N Progesterone Y or N

SOCIAL HISTORY:

Do you use:
Tobacco: Y N Current ___ Previous ___or Never ___ What form? _____
Amount Per Day _____ Number of Years _____
Alcohol: Y N If yes, What kind? _____ Amount per week _____
Other Substances: Y N Type _____ Amount/how often _____

MEDICATIONS OR SUPPLEMENTS:

List medications you are currently taking (1) _____
(2)_____ (3) _____ (4) _____ __
(5) _____ (6) _____ (7)_____ _
(8) _____ (9) _____ (10) _____

IMMUNIZATION HISTORY:

Please list the most recent date you received:
Tetanus: _____ Flu Vaccine: _____ Hep B: _____
Pneumovax Vaccine: _____ TB (PPD/TINE test): _____
TDap (Tetanus and whooping cough): _____ Zostavax (Shingles): _____

SIGNATURE:

Patient Signature: _____ **Date:** _____

If signed by authorized representative, print name of signee: _____