Weaver Health Services, LLC.

Ringgold Ready Clinic / Flintstone Ready Clinic

MEDICAL HISTORY for ADULTS

Patient's Name: _____

Patient's Date of Birth: _____ Today's Date: _____

Reason for todays visit _____

YOUR MEDICAL HISTORY - Please indicate if YOU have a history of the following:
Please CIRCLE all that apply

I HAVE NO SIGNIFICANT MEDICAL HISTORY

Alcohol Abuse
Allergies/Sinus
Alzheimers
Anemia
Anxiety
Arthritis
Asthma
Birth Defects
Bleeding Disease
Blood Clots
Breast Cancer
Bipolar Disorder
Cataracts
Colon Cancer
Congestive Heart Failure
COPD/Emphysema
Coronary Artery Disease
Crohn's Disease
Depression
Diabetes Type 1
Diabetes Type 2 (adult onset)
Gout
Heart Attack
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Hypothyroid (Low Thyroid)
Irritable Bowel Syndrome (IBS)
Kidney Stones
Liver Cancer
Lung Cancer
Lupus
Migraines
Multiple Sclerosis
Osteoporosis
Parkinson's Disease
Prostate Cancer
Prostate Problems
Reflux / GERD
Rheumatic Fever
Rheumatoid Arthritis
Seizures / Convulsions
Sexually Transmitted Disease
Sleep Apnea
Stomach Ulcer
Stroke / CVA of the Brain
Suicide Attempt
Tuberculosis (TB)

Other Disease, Cancer or Significant Medical Illness (please specify):

_____

SOCIAL HISTORY Are you employed? _____ Occupation: _____ Marital Status M S D W

TOBACCO/ALCOHOL USE

What is your smoking status?
- ❑ Never Smoke
- ❑ Former Smoker
- ❑ Currently every day smoker

If current smoker how many packs per day?_____

Gender:
- ❑ Male
- ❑ Female
- ❑ Transgender Male
- ❑ Transgender Female
- ❑ Decline to answer

Sexual Orientation:
- ❑ Staright
- ❑ Lesbian / Gay / Homosexual
- ❑ Bisexual
- ❑ Don't know
- ❑ Decline to answer

Do you drink alcohol?
If so, what type and how often? _____

SURGICAL HISTORY Please CIRCLE all surgeries you have had:

I HAVE HAD NO SURGERIES

Appendectomy
Breast Augmentation
Breast Lumpectomy
Breast Reduction
Carotid Artery
Cataract
Foot
Gallbladder
Heart Bypass
Hysterectomy (due to cancer)
Hysterectomy (not due to cancer)
Inguinal Hernia
Kidney Removal
Knee
Low Back Disc
Lung
Mastectomy
Neck Disc
Ovary Removal
Pacemaker
Prostate
Shoulder
Sinus
Thyroid Removal
Tonsillectomy
Total Hip Replacement
Total Knee Replacement
Tubal Ligation
Vasectomy
Weight Loss

List any other surgeries: _____

ALLERGIES ❑ No known allergies

DRUGS	SEVERITY				ONSET		
	Mild	Mod	Severe		Child	Adult	Unknown

Any other allergies to food or environment? _____

FAMILY MEDICAL HISTORY

- ❑ ADOPTED
- ❑ FAMILY HISTORY UNKNOWN
- ❑ NO SIGNIFICANT FAMILY MEDICAL HISTORY

- ❑ **Mother, Grandmother**, or **Sister** developed Heart Disease before the age of **65**.
- ❑ **Father, Grandfather**, or **Brother** developed Heat Disease before the age of **55**.

Please indicate which family member(s) have had these illnesses:	Father	Mother	Grandmother (Mother's side)	Grandfather (Mother's side)	Grandmother (Father's side)	Grandfather (Father's side)	Brother	Sister
Alcohol Abuse								
Anemia								
Arthritis								
Asthma								
Bipolar Disorder								
Bleeding Disease								
Breast Cancer								
Colon Cancer								
COPD / Emphysema								
Depression								
Diabtes Type 1								
Diabetes Type 2 (adult onset)								
High Blood Pressure								
High Cholesterol								
Osteopotosis								
Seizures / Convulsions								
Stroke / CVA of the Brain								

❑ Other Family Medical History (specify illness & family member):

_____

PREVENTATIVE HEALTH

Please indicate when you last had each of the applicable tests:	N/A	1 year or less	2 years ago	3 years ago	4 years ago	5 years ago	6 years ago	7 years ago	8 years ago	9 years ago	10+ years ago	Normal	Abnormal	I Don't Know
Mammogram														
Colonoscopy														
Pap Smear														
Bone Density / Dexa Scan														
Prostate Cancer Screening														
Stool Hemoccult (blood in stool)														
Eye Exam														

List all medications you are currently taking: _____

_____

_____

_____

LIVING WILL/POWER OF ATTORNEY

Do you have a Living Will or Power of Attorney for your healthcare? If yes, list details _____

_____

_____