Adult General History Form

Name:	Date of Birth:

Active Problems:		

Past Major Medical Problems:		

Surgeries:		

Medications, herbs, and supplements used:		

Allergies: (to medicine, environment, food and other)		

Family History	Age at death	Check if they had					Other medical conditions
		Heart disease	Stroke	Diabetes	Osteo-porosis	Cancer	
Father							
Mother							
Brother							
Sister							

Social History					
Marital Status:	Single ☐	Married ☐	Separated ☐	Divorced ☐	Widowed ☐
Occupation:_____	☐ Retired	☐ Disabled	☐ Unemployed		
Religion:_____	**Place of worship**: _____				
Drug Use:	☐ Never use ☐ Recovering addict	I currently use… ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other_____			
Alcohol:	☐ Never Drank ☐ Rarely Drink ☐ Daily drinker ☐ Weekend drinker ☐ Recovering Alcoholic				
Smoking:	☐ Never Smoked ☐ Used to Smoke ☐ Smoke Sometimes ☐ Smoke Every Day				

** Please bring your immunization records to office visit, thank you **