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ROGUE MEDICINE

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ADULT HEALTH HISTORY

It is important that you complete this form in full, including all dates.

PATIENT INFORMATION

Name (please print)________________ Date of birth________

Primary Care provider________________ Today's date________

MEDICAL HISTORY

Medical condition	Current?	Date diagnosed	Provider seen	*(Office use)*
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			

ALLERGIES

☐ No allergies

Allergic to:	**Reaction**	**Allergic to:**	**Reaction**

MEDICATIONS

Please include anything you are taking, including over-the-counter medications, herbal supplements, and vitamins.

Name	Current?	Prescribed by	What condition are you taking this medication for?	Dose	How do you take this medication
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				
	☐ Y ☐ N				

SURGERIES

Be sure to include the year you had the surgery.

Surgery/Procedure	Date	Physician/Surgeon

HEALTH MAINTENANCE

What is the date of your last:

Colonoscopy	
Tetanus vaccine	
Pneumonia vaccine	

WOMEN'S HEALTH HISTORY

If you are a woman, please fill in the information below.

Age menses started	
Age first child was born	
Age/year menopause	
Date of last PAP	
Date of last mammogram	
Total # of pregnancies	
# of full-term pregnancies	
# of pre-term pregnancies	
# of miscarriages	
# of abortions	
# of ectopic or tubal pregnancies	
# of live births - vaginal delivery	
# of live births - cesarean section	
# of children living now	

EDUCATION / MILITARY EXPERIENCE

High School graduate or GED equivalent? ☐ Y ☐ N

College ☐ Some ☐ Degree: ______________

Military experience ______________

EMPLOYMENT

Employer ______________

Occupation ______________

☐ Part-time ☐ Full-time ☐ Retired ☐ Disabled

FAMILY HISTORY

Have any of your relatives had any of the following?

Diagnosis	Relationship	Living?
ADD / ADHD		☐ Y ☐ N
Alcoholism		☐ Y ☐ N
Allergies		☐ Y ☐ N
Alzheimer's Disease		☐ Y ☐ N
Arthritis		☐ Y ☐ N
Asthma		☐ Y ☐ N
Bipolar Disorder		☐ Y ☐ N
Birth Defect type: ______		☐ Y ☐ N
Blood Disease		☐ Y ☐ N
Cancer type: ______		☐ Y ☐ N
CVA (Stroke)		☐ Y ☐ N
Depression		☐ Y ☐ N
Developmental Delay		☐ Y ☐ N
Diabetes		☐ Y ☐ N
Eczema		☐ Y ☐ N
Heart Disease		☐ Y ☐ N
High Cholesterol		☐ Y ☐ N
High Blood Pressure		☐ Y ☐ N
Learning Disability		☐ Y ☐ N
Lung Disease		☐ Y ☐ N
Mental Illness		☐ Y ☐ N
Migraines		☐ Y ☐ N
Obesity		☐ Y ☐ N
Osteoporosis		☐ Y ☐ N
Renal Disease		☐ Y ☐ N
Seizure Disorder		☐ Y ☐ N
Thyroid Disease		☐ Y ☐ N
Other: ______		☐ Y ☐ N
Other: ______		☐ Y ☐ N
Other: ______		☐ Y ☐ N

TOBACCO

Do you use tobacco? ☐ Y ☐ N

Type__________

How much/day?__________ Number of years__________

Have you tried to quit before? ☐ Y ☐ N

If yes, method?__________

☐ I quit Year__________

Passive (second-hand) smoke exposure? ☐ Y ☐ N

ALCOHOL

Do you drink alcohol? ☐ Y ☐ N

Type__________

How much?__________

How often? ☐ Daily ☐ Weekly ☐ Socially ☐ Binge

☐ I quit Year__________

CAFFEINE

Do you consume caffeine? ☐ Y ☐ N

Type__________

How much?__________

How often?__________

RECREATIONAL DRUGS

Do you take recreational drugs? ☐ Y ☐ N

Type__________

How much?__________

How often?__________

☐ I quit Year__________

EXERCISE/ACTIVITY

What is your normal activity level?

☐ Sedentary ☐ Moderate ☐ Athletic

How many hours per week do you exercise?__________

HOME ENVIRONMENT / SAFETY

Home heating type__________

DENTAL

Dentist__________

Date of last exam__________

ADVANCE DIRECTIVE

Below, check all documents you have in place:

☐ None

☐ Living Will

☐ Power of Attorney

☐ Healthcare Proxy