Jones Memorial Hospital 191 North Main Street Wellsville, NY 14895

JMH MEDICAL PRACTICE ADULT MEDICAL HISTORY

Form # 505 (01/19)

Name:	Date of Birth:
Allergies:	Date of Service:
Do you have a current Health Care Proxy?	Do you have a current Do Not Resuscitate Order?

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

Have you ever had any of the following:

- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Asthma / Emphysema / COPD
- ☐ Bladder/Kidney Infection
- ☐ Bleeding of any type
- ☐ Cancer
- ☐ Diabetes
- ☐ Cholesterol Problem
- ☐ Depression
- ☐ Schizophrenia
- ☐ Chronic Pain Syndrome
- ☐ Diverticulitis
- ☐ Epilepsy (seizures)
- ☐ Heart Attack
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hives
- ☐ Jaundice
- ☐ Lung Disease
- ☐ Mental Health Issues
- ☐ Other: _____
- ☐ Migraine Headaches
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Thyroid Problem
- ☐ Tuberculosis (TB)
- ☐ Ulcer / GERD / Reflux
- ☐ Anxiety
- ☐ Bipolar

Please list any surgeries and/or other hospitalizations that you have had:

Type of Surgery	Hospital	Date

When was your last:

Breast Exam:	Mammogram:	Pap Smear:
Colon Screening:	Colonoscopy:	Eye Exam:
Cholesterol Test:	Blood Glucose Test:	Bone Density Test:
Tetanus:	Flu Vaccine:	Pneumonia Vaccine:
Hepatitis Series:	HIV Screening	TSH Level:
Prostate Exam:	$HgbA_1C$	Complete Physical Exam:

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What medications are you now taking (including over-the-counter medications, aspirin, laxatives, etc)?

Medication	Amount	Times per day

Any history of sexually transmitted disease(s) ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes – How much? _____ ☐ Quit – When? _____

Do you drink alcohol? ☐ No ☐ Yes – How much? _____ ☐ Quit – When? _____

Do you have a history of substance abuse? ☐ No ☐ Yes

Any history of domestic violence/abuse? ☐ No ☐ Yes

FAMILY HISTORY

Has any blood relative ever had:	Yes	No	Relationship
Asthma			
Cancer			
Diabetes			
Heart Problems			
High Blood Pressure			
Tuberculosis			
Other Serious Illness			