Jones Memorial Hospital 191 North Main Street Wellsville, NY 14895

# JMH MEDICAL PRACTICE
# ADULT MEDICAL HISTORY

Form # 505 (10/08)

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

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

Have you ever had any of the following?

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

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

| Type of Surgery | Hospital | Date |
|---|---|---|
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When was your last:

| | | |
|---|---|---|
| Breast Exam | Mammogram: | Pap Smear: |
| Colon | Colonoscopy | Eye Exam: |
| Cholesterol | Blood Glucose | Bone Density Test: |
| Tetanus | Flu Vaccine | Pneumonia Vaccine: |
| Hepatitis | HIV Screening | TSH Level |
| Prostate Exam: | HgbA1C | Complete Physical |

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

| Medication | Amount | Times per day |
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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 | | | |
| | | | |