CROSS TRAILS MEDICAL CENTER

PATIENT HISTORY
ADULT / GERIATRIC LIFECYCLE
(Age 20+ years)

Date Completed _____ /_____ /_____

NAME:_____ **DATE OF BIRTH** _____/_____/_____

MARITAL STATUS: SINGLE MARRIED DIVORCED CHILDREN:__ OCCUPATION:_____

PAST MEDICAL HISTORY **(please write down or check all that apply to you)**

☐ Unremarkable	☐ Crohn's Disease	☐ Hepatitis A	☐ Thyroid Disorder
☐ Asthma	☐ Chronic Renal Failure	☐ Hepatitis B	☐ Tuberculosis
☐ Atrial Fibrillation	☐ Depression	☐ Hepatitis C	☐ Valvular Heart Disease
☐ Anemia	☐ Diabetes-Type I	☐ Infertility	☐ UTI - Recurrent
☐ Autoimmune Disorder	☐ Diabetes-Type 2	☐ Kidney Disease	☐ Varicose veins/Phlebitis
☐ Biliary Cirrhosis	☐ Diverticulitis	☐ Kidney Stone	☐ Other Cancer
☐ Blood transfusions	☐ DVT	☐ Heart attack	☐ Pap Smear
☐ Brain Tumor	☐ GI Bleed	☐ Neurological Disorder	☐ Mammogram
☐ Cerebrovascular Disease	☐ GERD	☐ Osteoarthritis	☐ Eye Exam
☐ Cirrhosis	☐ Hemochromatosis	☐ Osteoporosis	
☐ CVA / Stroke	☐ Hyperlipidemia	☐ Peripheral Venous Disease	
☐ COPD	☐ Hypertension	☐ Peptic Ulcer Disease	
☐ Colon Cancer	☐ Hyperthyroidism	☐ Rheumatoid Arthritis	
☐ Coronary Heart Disease	☐ Hypothyroidism	☐ Seizure Disorder	

OTHER PAST MEDICAL HISTORY:_____

_____

PREVIOUS SURGERIES: **(please write down and/or check all that apply)**

- ☐ Unremarkable
- ☐ Abdominal Surg-type
- ☐ Amputation
- ☐ AV Fistula Creation
- ☐ AV Graft
- ☐ Aortic Valve Replacement
- ☐ Back Surgery
- ☐ Bronchoscopy
- ☐ Coronary Bypass Surgery
- ☐ Carpal Tunnel
- ☐ Cataract Extraction
- ☐ Cholecystectomy
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement
- ☐ Knee arthroscopy
- ☐ Knee replacement
- ☐ Mitral Valve Replacement
- ☐ Pacemaker
- ☐ Parathyroidectomy
- ☐ Rotator Cuff Repair
- ☐ Tonsillectomy
- ☐ Urinary incontinence surgery
- ☐ Colonoscopy
- ☐ Anesthesia Prob - NO
- ☐ Anesthesia Prob - YES
- ☐ Surgical Complications - NO
- ☐ Surgical Complications - YES

OTHER SURGERIES:_____

_____

FAMILY HISTORY (please write down or check all that apply to you) Health problem

Mother: ☐ ALIVE ☐ DECEASED at age _____ _____

Father: ☐ ALIVE ☐ DECEASED at age _____ _____

Sibling1: ☐ ALIVE ☐ DECEASED at age _____ _____

Sibling2: ☐ ALIVE ☐ DECEASED at age _____ _____

(Check for any known history)	PARENTS		GRANDPARENTS				SIBLINGS	
	Father	Mother	Fraternal FGM/FGF		Maternal MGM/MGF		Brother	Sister
Heart disease								
Heart attack								
Stroke								
Hypertension								
Diabetes Mellitus								
Breast Cancer								
Ovarian Cancer								
Colon Cancer								
Other								

SOCIAL HISTORY **(please write down or check all that apply to you)**

Smoking status ☐ Current ☐ Former ☐ Never ☐ Unknown

How many cigarettes do you smoke a week? 1 Pack _____ How long have you smoked?_____

Do you use smokeless tobacco? 1 Pack _____ How long have you used this? _____

Alcohol Use ☐ Yes ☐ No How much do you drink?_____

Drug Use ☐ Yes ☐ No What type of drugs do you use?_____

HIV/High Risk ☐ Yes ☐ No _____

Regular Exercise ☐ Yes ☐ No How many times a week do you exercise? _____

ALLERGIES:

_____

_____

MEDICATIONS **Dosage** **Instructions**

_____

_____

_____

_____

_____

_____

Pharmacy

_____