Martha Jefferson Medical Group
SENTARA

ADULT
COMPREHENSIVE HEALTH HISTORY

Patient Name:	Patient Date of Birth:
Form completed by:	Date Completed:

As part of routine healthcare, we encourage every person over 18 to have an advance directive. To be useful, this document should name someone you trust to make decisions for you if you are ever unable to make decisions for yourself.

Do you have a healthcare Power of Attorney? ☐ **YES** ☐ **NO**

Do you have an advance directive? ☐ **YES** ☐ **NO** **If yes, please bring or mail a copy to our office.**

If you do not have an advance directive, please ask your provider for additional information.

PAST MEDICAL HISTORY *(include year if known)*

☐ Alcoholism	☐ Gallstones	☐ Parkinson's Disease
☐ Anemia	☐ Glaucoma	☐ Peripheral Nerve Disease
☐ Anxiety	☐ Gout	☐ Phlebitis
☐ Arthritis	☐ Headache	☐ Pneumonia
☐ Asthma	☐ Head Trauma	☐ Prostate Condition
☐ Atrial Fibrillation	☐ Hearing Loss	☐ Reflux/Heartburn
☐ Back Problem	☐ Heart Failure	☐ Seizure
☐ Bleeding Disorder	☐ Hepatitis	☐ Sinus Disease
☐ Blood Clots	☐ High Blood Pressure	☐ Skin Condition
☐ Bowel/Rectal Disease	☐ High Cholesterol	☐ Sleep Apnea
☐ Breathing Difficulty	☐ Incontinence	☐ Snoring
☐ Cancer (type)	☐ Infectious Disease	☐ Spinal Cord Disease
☐ Cataracts	☐ Implanted Cardiac Device	☐ STD
☐ Chest Pain	☐ Kidney Stones	☐ Stomach Ulcer
☐ Chronic Bronchitis	☐ Liver Disease	☐ Stroke
☐ COPD	☐ Lupus	☐ Thyroid Disorder
☐ Coronary Heart Disease	☐ Macular Degeneration	☐ Tuberculosis
☐ Depression	☐ Memory Disorder	☐ Valve Problem/Heart Murmur
☐ Diabetes	☐ Meningitis or Encephalitis	☐ Other:_____
☐ Drug Dependence	☐ Migraines	☐ Other:_____
☐ Eating Disorder	☐ Muscle Disease	
☐ Emphysema	☐ Obesity	Last Menstrual Period: _____
☐ Epilepsy	☐ Osteoporosis	Pregnancies(#)____Live Births(#) ____

CURRENT MEDICATIONS/VITAMINS/HERBS/SUPPLEMENTS *(please bring all medications with you)*

Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency

ALLERGIES

Allergies to Medications	☐ Latex	Environmental/Seasonal Allergies

What is your preferred local pharmacy? _____

SURGERIES *(include year if known)*

☐ Appendectomy	☐ Heart bypass	☐ Ovary (right/left) removed
☐ Back Surgery	☐ Hip Replacement	☐ Skin Cancer
☐ Breast Surgery	☐ Hernia	☐ Tonsillectomy
☐ C-Section	☐ Hysterectomy	☐ Tubal Ligation (BTL)
☐ Gallbladder	☐ Knee Replacement	☐ Vasectomy
☐ Other:	Have you ever had problems with general anesthesia? ☐ Yes ☐ No	

Have you been hospitalized in the past 12 months? ☐ **No** ☐ **Yes When:** _____

Reason: _____

Patient Name:	Date of Birth:

FAMILY HISTORY

☐ No Knowledge of blood relative history ☐ Adopted

Family Member	Alive/ Deceased	Age	Medical Condition
Father			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Mother			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Grandfather (Maternal)			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Grandfather (Paternal)			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Grandmother (Maternal)			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other:
Grandmother (Paternal)			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Brother-1			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Brother-2			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Sister-1			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other:
Sister-2			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Uncle			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____
Aunt			☐ Cancer: Type _____ ☐ Diabetes ☐ Heart Failure ☐ High Cholesterol ☐ High Blood Pressure ☐ Asthma ☐ Other: _____

MAJOR INJURIES/FRACTURES *(include year if known)*

MEDICAL TESTING *(include year of most recent if known)*

☐ Mammogram	☐ Colonoscopy	☐ PSA (Prostate Cancer Screening)
☐ Pap Smear	☐ Sigmoidoscopy	☐ CT Scan
☐ Bone Density test	☐ Stool Blood Test	☐ MRI
☐ EKG	☐ Exercise Stress Test	☐ Echocardiogram
☐ X-Ray	☐ HIV Test	☐ Other: _____

VACCINATIONS

☐ Flu		☐ Pneumovax (Pneumonia)		☐ Hepatitis B		☐ Meningitis	
☐ Tetanus		☐ Zostavax (Shingles)		☐ Gardasil (HPV)		☐ Other:_____	

SOCIAL HISTORY

With whom do you live? _____ **Pets? If yes, what type?** _____

Highest degree/level of education: _____

Have you traveled outside of the state or country in the past year? ☐ No ☐ Yes **Where:** _____

Which is your dominant hand? ☐ Right ☐ Left

Marital Status: ☐ Single ☐ Married ☐ Divorced or Separated ☐ Widowed ☐ Partnered

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled
Occupation (list previous if retired): _____

Tobacco: ☐ Never ☐ Smoke _____packs/day ☐ Chew ☐ Former Smoker Date Quit: _____
Alcohol: ☐ Never ☐ Occasional ☐ 1-2 /day ☐ More than 2/day
Recreational Drugs: ☐ Never ☐ Yes, what substance? _____

Exercise:
☐ None/Occasional ☐ 1-3 days/week ☐ 3+ days/week

Daily stress level: *(circle one)*
Low 1 2 3 4 5 6 7 8 9 10 High

Communication Needs: ☐ None ☐ Visually Impaired ☐ Hearing Impaired ☐ Interpreter ☐ Illiterate

Is there anything about your medical or personal history that you would like your health care provider to know?

Reviewed by: _____ **Date:** _____