MORONGO BASIN
COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

Adult Medical History Form

Today's Date:_____

Last Name: _____ First Name: _____ Date of Birth: _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin/Supplement (i.e. Atenolol)	**Dose/Strength** (e.g., 50mg)	**How many times per day** (i.e., once per day)

ALLERGIES: Do you have allergies or reactions to:

Medications	**Reaction**

Surgical History

Surgeries:	Year of the surgery	Reason for Surgery
1.		
2.		
3.		
4.		

PERSONAL HISTORY: Have you ever had problems with any of the following conditions:

	Yes	**No**		**Yes**	**No**
Heart disease	☐	☐	Sickle cell disease	☐	☐
High blood pressure	☐	☐	Kidney/bladder problems	☐	☐
Stroke	☐	☐	Seizures/epilepsy	☐	☐
Diabetes	☐	☐	Depression	☐	☐
High Cholesterol	☐	☐	Suicidal thoughts	☐	☐
Tuberculosis	☐	☐	Mental illness	☐	☐
Asthma	☐	☐	Severe headaches or migraines	☐	☐
Bleed/bruise easily	☐	☐	Liver problems or hepatitis	☐	☐
Anemia	☐	☐	Gallbladder disease	☐	☐
Cancer Type:_____	☐	☐	Eating disorder	☐	☐
Fibroids (women only)	☐	☐	Ovarian cyst/abnormality (women only)	☐	☐
Other Medical Conditions	☐	☐	Prostate Disorder	☐	☐

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WOMEN'S HEALTH

Number of pregnancies_____
Number of live births_____
Number of abortions_____
Number of miscarriages_____
Number of ectopic (tubal) pregnancies_____

When was your last pap smear? _____ I have never had a pap smear_____
Have you ever had an abnormal pap smear?
❑ No ❑ Yes If yes, when? _____

First day of last period_____Periods come every day and last ___days
Periods are ❑ Regular ❑ Irregular ❑ Painful ❑ Light ❑ Moderate ❑ Heavy
Do you have spotting or bleeding between periods?
❑ No ❑ Yes

Have you ever had a mammogram?
❑ No ❑ Yes
If yes, when was your last one? _____
Was it normal? _____

MEN'S HEALTH

When was your last genital exam?_____ ❑ Never had

Habit and Lifestyle

Tobacco Use
Cigarettes:
☐ Never Quit Date_____ Current Smoker: packs/day _____ # of yrs _____
Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew ❑ Vaping Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use
Do you drink alcohol? ❑ No ❑ Yes # drinks/week _____
Is your alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use
Do you use street drugs? If yes, please list:_____
4. Have you ever used injectable drugs? ❑ No ❑ Yes
5. Have you ever shared needles? ❑ No ❑ Yes
6. Has anyone ever told you that you have a problem with drugs or alcohol? ❑ No ❑ Yes

Have you ever had an HIV test? ❑ No ❑ Yes if yes, when?_____ What were the results? _____

Have you ever had a Hepatitis C test? ❑ No ❑ Yes if yes, when?_____ What were the results? _____

Immunizations	Health Maintenance
Date of your last Flu shot: _____	Date of your last physical: _____
Date of your last Pneumonia shot: _____	Date of your last colonoscopy: _____
Date of your last Hepatitis B shot: _____	
Date of your last Shingles shot: _____	
Date of your last Tetanus shot: _____	
Covid-19: ☐ None ☐ 1st Brand _____ (Moderna, Pfizer, Johnson & Johnson) ☐ 2nd Brand _____ (Moderna, Pfizer, Johnson & Johnson) ☐ Booster Brand _____ (Moderna, Pfizer, Johnson & Johnson)	

DENTAL HISTORY

Date of last dental visit_____ Date of last x-rays _____
History of injury to teeth or jaws: ❑ No ❑ Yes Describe:_____
History of dental pain: ❑ No ❑ Yes
History of dental infections: ❑ No ❑ Yes

_____
Signature of person completing the form Date

_____
Provider Signature Date