

JSFP Adult Patient History Form

Welcome to Jefferson Street Family Practice and thank you for choosing us as your medical home. Thorough and accurate medical records help us provide you with the best quality medical care. Thank you for taking the time to complete this summary.

Today's date:

PAST MEDICAL HISTORY: Please list any current or past medical problems and the date diagnosed.

Date	Diagnosis

Have you experienced any of the following problems? If yes, please circle and explain below.

- General: Recurrent fever, unexplained weight change, fatigue, other: None
- Head: Allergies, recurrent ear/throat infections, problems with vision/hearing, glaucoma other: None
- Neck: Chronic swollen glands, lump in the neck, thyroid problem, other: None
- Respiratory: Chronic cough, problems breathing, asthma, emphysema, other: None
- Heart: Chest pain, heart disease, high blood pressure, high cholesterol, other: None
- Gastrointestinal: Chronic abdominal pain, hernia, liver disease, appendix/gallbladder problem: None
- Kidney: Kidney disease, recurrent urinary tract infections, problems urinating, other: None
- Musculoskeletal: Recurring pain in joint, muscle problems, arthritis, gout, other: None
- Blood/Infections: Anemia, HIV, Hepatitis, STD, chickenpox, rheumatic fever, other: None
- Mental health: Depression, Anxiety, Bipolar disorder, other: None

Please explain any circles and give dates of occurrence:

SURGERY/HOSPITALIZATION: Please list any surgeries, reason for hospitalization and the date:

MEDICATION ALLERGIES: Please list any medications to which you are allergic and tell us what happened when you took the medication:

Please tell us about your social habits: Have you ever consumed any of the following?

Alcohol	Yes	No	Drinks per week?	Year started:	Year stopped:
Tobacco	Yes	No	Packs per day?		
Street drugs	Yes	No	Type(s)?		

