

Weaver Health Services, LLC.  
**2022 Ready Clinic**  
 MEDICAL HISTORY for ADULTS

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

**YOUR MEDICAL HISTORY** - Please indicate if YOU have a history of the following:  
 Please CIRCLE all that apply

**I HAVE NO SIGNIFICANT MEDICAL HISTORY**

- |                     |                               |                                |                              |
|---------------------|-------------------------------|--------------------------------|------------------------------|
| Alcohol Abuse       | Cataracts                     | High Blood Pressure            | Parkinson's Disease          |
| Allergies/Sinus     | Colon Cancer                  | High Cholesterol               | Prostate Cancer              |
| Alzheimers          | Congestive Heart Failure      | HIV/AIDS                       | Prostate Problems            |
| Anemia              | COPD/Emphysema                | Hypothyroid (Low Thyroid)      | Reflux / GERD                |
| Anxiety             | Coronary Artery Disease       | Irritable Bowel Syndrome (IBS) | Rheumatic Fever              |
| Arthritis           | COVID-19                      | Kidney Stones                  | Rheumatoid Arthritis         |
| Asthma              | Crohn's Disease               | Liver Cancer                   | Seizures / Convulsions       |
| Atrial Fibrillation | Depression                    | Lung Cancer                    | Sexually Transmitted Disease |
| Birth Defects       | Diabetes Type 1               | Lupus                          | Sleep Apnea                  |
| Bleeding Disease    | Diabetes Type 2 (adult onset) | Migraines                      | Stomach Ulcer                |
| Blood Clots         | Gout                          | Multiple Sclerosis             | Stroke / CVA of the Brain    |
| Breast Cancer       | Heart Attack                  | Osteoarthritis                 | Suicide Attempt              |
| Bipolar Disorder    | Hepatitis                     | Osteoporosis                   | Tuberculosis (TB)            |

Other Disease, Cancer or Significant Medical Illness (please specify):  
 \_\_\_\_\_

**SOCIAL HISTORY** Are you employed? \_\_\_\_\_ Occupation: \_\_\_\_\_ Marital Status M S D W

**TOBACCO/ALCOHOL USE**

What is your smoking status?

- Never Smoke  
 Former Smoker  
 Currently every day smoker

If current smoker how many packs per day? \_\_\_\_\_

Do you eat healthy meals? \_\_\_\_\_ Do you exercise regularly? \_\_\_\_\_

Do you use any drugs? \_\_\_\_\_

Do you take a daily aspirin? \_\_\_\_\_

**Do you drink alcohol?**

If so, what type and how often? \_\_\_\_\_

**SURGICAL HISTORY** Please CIRCLE all surgeries you have had:

**I HAVE HAD NO SURGERIES**

- |                     |                                  |                        |                |
|---------------------|----------------------------------|------------------------|----------------|
| Aneurysm Repair     | Hysterectomy (due to cancer)     | Ovary Removal          | Tubal Ligation |
| Appendix Removed    | Hysterectomy (not due to cancer) | Pacemaker              | Vasectomy      |
| Breast Augmentation | Inguinal Hernia                  | Prostate               | Weight Loss    |
| Breast Lumpectomy   | Kidney Removal                   | Shoulder               |                |
| Breast Reduction    | Kidney Stone Surgery             | Sinus                  |                |
| Carotid Artery      | Knee                             | Spine Surgery          |                |
| Cataract            | Low Back Disc                    | Thyroid Removal        |                |
| Foot                | Lung                             | Tonsillectomy          |                |
| Gallbladder         | Mastectomy                       | Total Hip Replacement  |                |
| Heart Bypass        | Neck Disc                        | Total Knee Replacement |                |

List any other surgeries: \_\_\_\_\_

Hospitalizations: List any hospital stays & dates: \_\_\_\_\_

**ALLERGIES**  No known allergies

DRUGS	SEVERITY			ONSET		
	Mild	Mod	Severe	Child	Adult	Unknown

Any other allergies to food or environment? \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

- ADOPTED
- FAMILY HISTORY UNKNOWN
- NO SIGNIFICANT FAMILY MEDICAL HISTORY

**Mother, Grandmother, or Sister** developed Heart Disease before the age of **65**.

**Father, Grandfather, or Brother** developed Heart Disease before the age of **55**.

Please indicate which family member(s) have had these illnesses:

	Father	Mother	Grandmother (Mother's side)	Grandfather (Mother's side)	Grandmother (Father's side)	Grandfather (Father's side)	Brother	Sister
Alcohol Abuse								
Anemia								
Arthritis								
Asthma								
Bipolar Disorder								
Breast Cancer								
Colon Cancer								
COPD / Emphysema								
Depression								
Diabetes Type 1								
Diabetes Type 2 (adult onset)								
High Blood Pressure								
High Cholesterol								
Osteoporosis								
Seizures / Convulsions								
Stroke / CVA of the Brain								

Other Family Medical History (specify illness & family member):

\_\_\_\_\_

-----

List any hospital stays for past 5 years \_\_\_\_\_

\_\_\_\_\_

**PREVENTATIVE HEALTH**

Last Flu Shot \_\_\_\_\_

Last COVID Vaccine \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_