Keystone Internal Medicine
Adult Health History Form

Medical History: Please **Circle** any diseases you have or have had in the past

Allergies	Cardiac arrhythmia	Heart valve disorder
Anemia	COPD	Hepatitis/ liver disease
Angina/chest pain	Coronary artery disease	Hypertension/blood pressure
Anxiety	Depression	Irritable bowel disease
Arthritis	Diabetes/sugar	Myocardial infarction/heart attack
Asthma	Elevated lipids/cholesterol	Osteoporosis
Atrial fib/abnormal heart rhythm	Gallbladder disease	Renal disease/kidney
Benign prostatic hypertrophy	GERD/acid reflux	Seizure disorder
Blood clots	Headache, migraine	Stroke
Cancer	Heart disease	Thyroid disease

Other:

_____

FAMILY HISTORY: Please **Circle** any diseases your parents, grandparents, brother, sister, aunts or uncles have /had. Please indicate which relative has/had it.

ADD/ADHD	Depression	Mental Illness
Alcoholism	Developmental delay	Migraines
Allergies	Diabetes	Obesity
Alzheimer's disease	Eczema	Osteoporosis
Arthritis	Elevated Lipids	Peripheral vascular disease
Asthma	Genetic Deficiency	Renal Disease
Blood disorder	Hearing Deficiency	Seizure Disorder
Cancer	Hypertension	Stroke
Cardiovascular disease/Heart attack	Irritable bowel disease	Thyroid disorder
Coronary artery disease	learning disability	

Other:

_____

Surgical History: Please **Circle** any surgeries you have had

Angioplasty	CABG	Colectomy	Knee replacement
Appendectomy	Cardiac pacemaker	Colostomy	LASIK
Arthroscopy	Carpal tunnel release	Gastric bypass	ORIF
Back surgery	cataract extraction	hernia repair	Thyroidectomy
Blood transfusion	cholecystectomy	Hip replacement	Tonsillectomy

Other:

_____

Medications: Prescription and non-prescription medicines (may attach med list).

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies or reactions to medications: Indicate the specific reaction you had

_____ _____ _____

_____ _____ _____

Patient Signature: _____ Date:_____

Providers Initials: _____ Date: _____