Enterprise Valley
MEDICAL CLINIC

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This form provides information about your health history; it is confidential and part of your medical record. If you do not understand a question or word, please ask for assistance.

ADULT HEALTH HISTORY

Name: _____ **Date of Birth:** _____ **Race/Ethnicity:** _____

Preferred Language:_____ **How did you hear about our clinic or who referred you?** _____

MEDICAL HISTORY

Have you ever been diagnosed or have any of the following?

- ○ Anemia
- ○ Anxiety
- ○ GERD/Acid Reflux
- ○ Cancer

If so, please specify

_____

- ○ Stroke
- ○ Hypertension
- ○ Kidney Disease
- ○ Diabetes Mellitus
- ○ Seizures
- ○ Hepatitis
- ○ Clotting Disorder
- ○ Asthma
- ○ Heart Murmur
- ○ CHF
- ○ Thyroid Disease
- ○ Depression
- ○ Heart Attack
- ○ Arthritis
- ○ HIV/AIDS
- ○ COPD
- ○ High Cholesterol

Hospitalizations

_____

_____

_____

Are you pregnant or plan to become pregnant? ○ Yes ○ No

Surgical History

- ○ Appendectomy
- ○ Brain Surgery
- ○ Spinal Surgery
- ○ Tubal Ligation
- ○ C-Section
- ○ Eye Surgery
- ○ CABG
- ○ Gallbladder Surgery
- ○ Breast Surgery
- ○ Hernia Repair
- ○ Hysterectomy
- ○ Cosmetic Surgery
- ○ Valve Replacement
- ○ Prostate Surgery
- ○ Colon Surgery
- ○ Adenoid/Tonsil Removal

Allergies

_____

_____

_____

Do you have a family history of any chronic illnesses?

_____

_____

_____

MEDICATIONS

Please specify the medication's name, dose and frequency. If you have a list please write see attached.

_____

_____

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