Daughters of Charity Services of Arkansas

ADULT PAST MEDICAL/FAMILY/SOCIAL HISTORY

NAME________________________________ BIRTHDATE__________ DATE__________

PAST MEDICAL HISTORY:

LIST PAST HOSPITALIZATIONS (Include Dates)______________________________________

____

Have you had any of the following?

Anemia .... Yes___No___
Anxiety.. Yes___No___
Arthritis .... Yes___No___
Asthma .... Yes___No___
Backache .... Yes___No___
Birth Defect.................................. Yes___No___
Bleeding .... Yes___No___
Blood Transfusion .... Yes___No___
Bone Disorder .... Yes___No___
Cancer .... Yes___No___
Cardiovascular Disorder.................... Yes___No___
COPD .... Yes___No___
Depression.................................... Yes___No___
Diabetes...................................... Yes___No___
Dizziness .... Yes___No___
Ear Infections .... Yes___No___
Emphysema.................................... Yes___No___
Epilepsy...................................... Yes___No___
Eyesight Problems........................... Yes___No___
Fainting .... Yes___No___
Gallbladder Disease .... Yes___No___
Gastric Ulcers................................ Yes___No___
Glaucoma .... Yes___No___
Gout... Yes___No___
Headaches .... Yes___No___
Hearing Loss .... Yes___No___
Heart Disease .... Yes___No___
Hepatitis .... Yes___No___
HIV Infection .... Yes___No___
High Blood Pressure .... Yes___No___
Liver, Stomach, or Bowel Disease...... Yes___No___
Meningitis .... Yes___No___
Muscle, Ligament or Fascia Disorder... Yes___No___
Nonmoving limbs (paralysis)............. Yes___No___
Numbness..................................... Yes___No___
Osteoporosis................................. Yes___No___
Renal Disease (kidney) .... Yes___No___
Respiratory Disorders....................... Yes___No___
Seizure Disorders .... Yes___No___
Sickle Cell Abnormality.................... Yes___No___
Skin Disorders............................... Yes___No___
Spine Disorder .... Yes___No___
Stroke... Yes___No___
Thyroid Disease .... Yes___No___
Tuberculosis .... Yes___No___
Upper Respiratory Infections
(Chronic)..................................... Yes___No___
Urinary Tract Infections .... Yes___No___
Venereal Disease (STD) .... Yes___No___

SURGICAL HISTORY:
Any Past Surgery Yes___No___
If Yes, please list type and date of surgery:____
____

TRAUMA HISTORY:
Any Past Physical Trauma (motor vehicle accidents, falls, etc.) ______________________________
____

SOCIAL HISTORY:
Education: Years completed __________
Working (please check one): Full Time___Part Time___Disability___Other___

Living Situation (please check one):
- With Spouse or Significant Other __________
- Alone __________
- With parents __________
- Other __________
- Nursing Home __________

Number of Children __________

Marital Status (please check one):
- Married __________
- Single __________
- Separated __________
- Divorced __________
- Widowed __________
- Military History __________

Substance Use:
- Caffeine use Yes___No___
- Coffee (cups per day) __________
- Other caffeine use __________
- Alcohol Use Yes___No___
- Previous Smoker Yes___No___
- Chew Tobacco Yes___No___
- Smoking Cigarettes Yes___No___
- Drug Use Yes___No___

FAMILY HISTORY: Have your family members had any of the following?

	Mom	Dad	Brother	Sister	Son	Daughter
DIABETES						
TUBERCULOSIS						
HEART DISEASE						
HIGH BLOOD PRESSURE						
STROKE						
CANCER						
SEIZURES						
MENTAL ILLNESS						

Mother's age _____
Mother's deceased age _____
Father's age _____
Father's deceased age _____

ADVANCE DIRECTIVES: Living Will ___ None in Place ___ Other ______________________