ADULT MEDICAL HISTORY FORM

Name: ____ Date: ____________________

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

What is the reason for your visit with Dr. Karam today? ________________________________

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/ weakness

Eyes
- ☐ Change in vision

Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing/ringing in ears
- ☐ Trouble swallowing
- ☐ Sinus Allergies

Cardiovascular
- ☐ Chest pain/discomfort
- ☐ Palpitations
- ☐ Shortness of breath with exertion

Breast
- ☐ Breast lump
- ☐ Nipple discharge

Respiratory
- ☐ Cough/wheeze

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Blood or change in bowel movement
- ☐ Nausea/vomiting/diarrhea

Genitourinary
- ☐ Painful/bloody urination
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Discharge: penis or vagina
- ☐ Unusual vaginal bleeding
- ☐ Concern with sexual functions

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Back pain

Skin
- ☐ Rash
- ☐ New or change in mole

Neurological
- ☐ Memory loss
- ☐ Fainting

Psychiatric
- ☐ Anxiety/stress
- ☐ Sleep Problem

Blood/Lymphatic
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Endocrine
- ☐ Cold/heat intolerance
- ☐ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, felt sad or down, depressed or hopeless?
YES: _____ NO: _____

Do you have any ALLERGIES or reactions to any MEDICATIONS or other non-medications?
YES: _____ NO: _____ If answer is yes, please list **MEDICATION and TYPE of REACTION** on first line and other allergies (foods, seasonal) on the second line: ________________________________

____

____

SURGICAL HISTORY: Please list **ANY and ALL prior operations (including as a child**) and provide dates, if unsure, please include your age or year: ________________________________

____

____

____

____

Abdallah Karam, MD, SC
2101 South Arlington Heights Road, Suite 100 | Arlington Heights, IL 60660 Phone: (847) 427-2100 Fax: (847) 427-2111

ADULT MEDICAL HISTORY FORM

Name: ______________________________ Date: ______________

Date of your most recent **IMMUNIZATIONS**:

Hepatitis A ______________

Hepatitis B ______________

Influenza (flu shot) ______________

MMR ______________

Tetanus (Td) ______________

Pneumovax (pneumonia) ______________

Meningitis ______________

Varicella (chicken pox) shot or Illness ______________

HPV ______________

Zostavax (Shingles) ______________

HEALTH MAINTENANCE SCREENING TESTS:

☐ Lipid (cholesterol) & Sugar: Date ______________ Abnormal? ☐ YES ☐ NO

☐ Sigmoidoscopy or ☐ Colonoscopy: Date ______________ Abnormal? ☐ YES ☐ NO

Women: Mammogram: Date ______________ Abnormal? ☐ YES ☐ NO

Pap Smear: Date ______________ Abnormal? ☐ YES ☐ NO

☐ Dexa Scan (for bone density): Date ______________ Abnormal? ☐ YES ☐ NO

Women's Health History:
Number of: pregnancies ________ deliveries ________ abortions ________ miscarriages ________

Age at start of periods: ________ Date of Last Period: ________ Age at end of periods: ________

Name and phone number of your OB/Gynecologist: ______________________________

Men's Health History:
Have you had a blood test for: PSA (prostate): Date ______________ Abnormal? ☐ YES ☐ NO

PERSONAL MEDICAL HISTORY
Please indicate whether YOU have had any of the following medical problems (with dates).

☐ Alcoholism ______________
☐ Anxiety / Depression ______________
☐ Cancer, specify type ______________
☐ Heart disease ______________
☐ Diabetes ______________
☐ Stroke ______________
☐ Urinary / Kidney Problems ______________
☐ Arthritis / Rheumatologic ______________
☐ Bleeding or Clotting disorder or Blood Clot ______
☐ Thyroid problems ______________
☐ High Blood Pressure ______________
☐ High Cholesterol ______________
☐ Other ______________
____

DO YOU SEE ANY OTHER DOCTORS?
If yes, please list their name, office phone number and specialty.

____
____
____
____
____

Abdallah Karam, MD, SC
2101 South Arlington Heights Road, Suite 100 | Arlington Heights, IL 60660 Phone: (847) 427-2100 Fax: (847) 427-2111

ADULT MEDICAL HISTORY FORM

Name: ____ Date: ______________________

FAMILY HISTORY

Please indicate the current status of your immediate family members:

Blood Relative	**Date of Birth**	**Alive/Deceased** (list age when died)	**List any Health Problems or Cause of Death**
Father			
Mother			
Brother			
Brother(s)			
Sister			
Sister(s)			
Child (Son)			
Child (Daughter)			
Children			

Abdallah Karam, MD, SC
2101 South Arlington Heights Road, Suite 100 | Arlington Heights, IL 60660 Phone: (847) 427-2100 Fax: (847) 427-2111

ADULT MEDICAL HISTORY FORM

Name: ____ Date: ___________________

SOCIAL HISTORY

Cigarettes

☐ Never ☐ Quit Date _____________

☐ Current Smoker: packs/day _______ # of yrs _____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ YES ☐ NO

Alcohol Use

Do you drink alcohol? ☐ YES ☐ NO

If yes, how many drinks per day _________________

how many drinks per week? _______________

how many drinks per occasion? _____________

SEXUAL ACTIVITY

Sexually active? ☐ YES ☐ NO ☐ Not currently

Current sex partner(s) is/are: ☐ Male ☐ Female

Birth control method: _________________________

____

☐ None needed

☐ Unprotected intimate contact

Have you ever had any sexually transmitted diseases (STDs)? ☐ YES ☐ NO

Are you interested in being screened for sexually transmitted diseases? ☐ YES ☐ NO

OTHER

Hobbies: ____________________________________

____

____

____

____

____

CAFFEINE USE

☐ None ☐ Coffee _____ cups/day

☐ Tea _____ cups/day ☐ Soda _____ cups/day

WEIGHT

Are you satisfied with your weight?
☐ YES ☐ NO

If no, are you currently trying to lose weight?
☐ YES ☐ NO

If yes, what method are you using and for how long have you been trying?

____

____

____

DIET

How do you rate your diet?
☐ Good ☐ Fair ☐ Poor

RECREATIONAL DRUG USE

Do you use any recreational drugs?
☐ YES ☐ NO

Have you ever used needles to inject drugs?
☐ YES ☐ NO

EXERCISE

Do you exercise regularly?
☐ YES ☐ NO

If yes, what kind(s) of exercise or physical activity:

____

____

____

____

Abdallah Karam, MD, SC
2101 South Arlington Heights Road, Suite 100 | Arlington Heights, IL 60660 Phone: (847) 427-2100 Fax: (847) 427-2111