KACHINA FAMILY MEDICINE ADULT MEDICAL HISTORY (18+)

Personal Information

Full Name: _____ Today's Date: _____
Last First DOB Age

Email: _____ Preference for Rx: ☐ 30 day or ☐ 90 day supply

Pharmacy: _____
Name & Cross Streets Pharmacy Phone Number

Current Medications: *Dose Times/day* *Dose Times/day*

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allergies to Medications & Reactions: _____

Medical History

☐ADD/ADHD	☐Asthma	☐GERD	☐Migraines	☐Cancer, Type:
☐Allergies	☐COPD/Emphysema	☐Heart Disease	☐Osteoporosis	
☐Anemia	☐Depression	☐High Blood Pressure	☐Skin Disorder	☐Other:
☐Anxiety	☐Diabetes Type: ☐ I ☐ II	☐High Cholesterol	☐Sleep Apnea	
☐Arthritis	☐Erectile Dysfunction	☐Hypothyroidism		

Surgeries*: (type and year)* ☐None _____

OB/GYN:
Pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____ Last PAP: _____ with ☐PCP ☐GYN

Lifestyle

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered

Children: Boys: _____ Girls: _____ Pets: _____ Occupation: _____

Who do you live with? _____ Hobbies? _____

Years in AZ? _____ Previous states? _____

Are you sexually active? ☐Yes ☐No Sexual Orientation: I prefer ☐Men ☐Women ☐Both

Tobacco: ☐Yes ☐No ☐Former Years: _____ Type: ☐Cigarettes _____packs/day ☐Cigars ☐Smokeless

Alcohol: ☐Yes ☐No ☐Former Amount: _____ drinks per ☐day ☐week ☐month ☐year Drugs: ☐Yes ☐No ☐Former

Nutrition: ☐Excellent ☐Good ☐Average ☐Needs Improvement ☐Poor ☐Lots of Fast Food

Exercise: ☐None Types: _____ Frequency: For _____ minutes, ____days per week.

Family Medical History

☐ **ADOPTED (Skip to Preventative Care)**

Mother:		**Father:**		**Siblings:**	
☐Alive ☐Deceased Age: _____		☐Alive ☐Deceased Age: _____		Number of Brothers: _____ Sisters: _____	
Cause of death: _____		Cause of death: _____		Cause(s) of death: _____	
Medical Issues:		Medical Issues:		Medical Issues:	
☐Alcoholism	☐High Blood Pressure	☐Alcoholism	☐High Blood Pressure	☐Alcoholism	☐High Blood Pressure
☐Anxiety	☐High Cholesterol	☐Anxiety	☐High Cholesterol	☐Anxiety	☐High Cholesterol
☐Asthma	☐Kidney Disease	☐Asthma	☐Kidney Disease	☐Asthma	☐Kidney Disease
☐Depression	☐Migraines	☐Depression	☐Migraines	☐Depression	☐Migraines
☐Diabetes	☐Obesity	☐Diabetes	☐Obesity	☐Diabetes	☐Obesity
☐Heart Disease	☐Osteoporosis	☐Heart Disease	☐Osteoporosis	☐Heart Disease	☐Osteoporosis
☐Cancer, Type:	☐Other:	☐Cancer, Type:	☐Other:	☐Cancer, Type:	☐Other:

Preventative Care

Date of last:

Physical _____ Colonoscopy _____ Mammogram _____

Vaccines: Tetanus _____ Pneumonia _____ Flu _____ Shingles _____

How did you hear about us? _____

Patient Signature: _____ Date: _____