

Monterey County Clinic Services

Adult Medical History

Name	Date of Birth	Age:
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Have you been seen at another doctors office or clinic?

Name of clinic or doctor:

Tobacco Use:

- I have never Smoked
- Yes, I smoke: \_\_\_\_\_ packs/Cigarettes daily
- I chew Tobacco
- I am around Second hand Smoke

Allergies

Allergies	Reaction

Medications Are you currently taking any medications?  Yes  No

Immunizations

Date of last:	Flu:	Date:	<input type="checkbox"/> NEVER
	Pneumococcal:	Date:	<input type="checkbox"/> NEVER
	Tdap (pertussis):	Date:	<input type="checkbox"/> NEVER

Have you ever had a Positive TB skin Test (PPD) ?  Yes  NO

Males & Females Over 50 Yrs of Age:

Have you had a Colonoscopy:  Yes  NO when? \_\_\_\_\_ Where?

Have you received the Shingles Vaccine?  Yes  NO when? \_\_\_\_\_

Females:

Last menstrual period:

Last Pap Smear Date: \_\_\_\_\_ where: \_\_\_\_\_  NEVER

Have you had an abnormal Pap Smear in the past?  Yes  NO

Have you had a Mammogram? Date: \_\_\_\_\_ where: \_\_\_\_\_  NEVER

Have you had a Bone Density test to check for osteoporosis  NEVER

when? \_\_\_\_\_ where? \_\_\_\_\_

