MONTEREY COUNTY
HEALTH DEPARTMENT
Clinic Services Bureau

Adult Medical History *(16 years and over)*

Name:	**Date of Birth:**	**Age:**

Medication Allergies	**Reaction**
□ None	

Medications / Supplements (Please List)
□ None
Please bring in all medications you are taking (either bottles or list)

Patient Medical History *(Check all that apply)*

	Abuse as Adult (Victim)		Heart Failure
	Abuse as Child (Victim)		Heart murmur
	Allergies		HIV/AIDS
	Anemia		Hyperlipidemia
	Anxiety		Hypertension
	Arthritis/Joint disorder		Kidney disease
	Asthma		Liver disease
	Blood Transfusion		Meningitis
	Cancer		Myocardial infarction
	Cataracts		Nerve / Muscle disease
	Clotting Disorder		Osteoporosis
	COPD		Seizures
	Depression		Sickle cell anemia
	Diabetes Mellitus		Stomach ulcers
	Emphysema/COPD		Stroke
	Glaucoma		Thyroid disease
	Heart Disease		Tuberculosis

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Patient Surgical History

Surgery	Date

Family Medical History

Medical Conditions	Who? Mom/Dad/Brother/Aunt/Grandparents
Alcohol/Drug Abuse	
Arthritis	
Asthma	
Cancer	
Heart Problems	
Depression	
Diabetes	
High Cholesterol	
Hypertension	
Kidney Disease	
Liver Disease	
Mental Illness	
Stroke	
Vision Problems	
Unknown	
Gastrointestinal	
No Significant family history	