

## ADULT MEDICAL HISTORY LUTHERAN BIBLE TRANSLATORS, INC.

**GENERAL**

Date \_\_\_\_\_

Name \_\_\_\_\_ Occupation \_\_\_\_\_

Weight \_\_\_\_\_ Has your weight gone up or down during the past year? \_\_\_\_\_ How much \_\_\_\_\_ Height \_\_\_\_\_

Birthplace \_\_\_\_\_ Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widow \_\_\_\_\_

Birth date \_\_\_\_\_ Date of marriage(s) \_\_\_\_\_

Probable field of service \_\_\_\_\_ Ages of children, if any \_\_\_\_\_

Describe your fitness program \_\_\_\_\_

Among your blood relatives describe any (a) hypertension, (b) arthritis, (c) asthma, (d) diabetes, (e) epilepsy, (f) thyroid Problem, (g) hay fever, (h) heart or any circulatory or blood disease, (i) insanity or any mental disorder, (j) mental retardation, (k) nervous breakdown, (l) recurring sick headaches, (m) tuberculosis, or (n) any genetic disabilities. Specify relative, disease, age when occurred and degree and duration of your contact:

Give the following data about your birth family. Use B or S for brother or sister.

IF LIVING			IF NOT LIVING				Previous health
Age	Health (well or ill) If not well, give diagnosis	Cause of death	How long ill	Year of death	Age at death	Details	
Father							
Mother							
Siblings (No. 1)							
(No. 2)							
(No. 3)							
(No. 4)							
(No. 5)							
(No. 6)							

**PAST HISTORY**

Please give dates if you have had any of the following and state whether severe (s), moderate (m), or light (l).

Allergic Reactions _____ Amoebic Dysentery _____ Anemia _____ Asthma _____ Cancer _____ H.I.V. _____ Diabetes _____ Tuberculosis _____ Rheumatic Heart Disease _____ Epilepsy _____ D.V.T./Blood Clots/Embolism _____ Venereal Disease _____	Hemorrhoids (Piles) _____ Jaundice _____ Kidney Stones _____ Typhoid _____ Malaria _____ Pneumonia _____ Whooping Cough _____ Arthritis _____ Serious illness of any kind _____ Serious injuries _____ Disabilities _____ Peptic Ulcer _____
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Please indicate with a check mark if you have ever been advised to have any of the following tests (other than at the time of a routine physical):

Heart tests \_\_\_\_\_ Blood tests \_\_\_\_\_ Specialist consultation \_\_\_\_\_ Operations \_\_\_\_\_ Spinal fluid examination \_\_\_\_\_  
 X-ray examination or x-ray treatments \_\_\_\_\_ CT scans or MRI exams \_\_\_\_\_  
 Have you ever been rendered unconscious because of a blow on the head? \_\_\_\_\_ Been overcome by heat? \_\_\_\_\_  
 Had a nervous breakdown? \_\_\_\_\_ Had sunstroke? \_\_\_\_\_ Had frostbite? \_\_\_\_\_ Had chemical poisoning? \_\_\_\_\_  
 Are you now or have you been treated by any physician, osteopath or chiropractor within the past two years? \_\_\_\_\_  
 If so, for what? \_\_\_\_\_  
 When was your last chest x-ray? Date \_\_\_\_\_ Result \_\_\_\_\_ Tuberculin test? Date \_\_\_\_\_ Result \_\_\_\_\_  
 List immunizations you have had with the date \_\_\_\_\_

Have you any physical, emotional or mental disability? \_\_\_\_\_

Have you ever consulted a psychologist, psychiatrist and/or other counselor? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Since age 17, have you had a homosexual experience? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

## SYSTEMIC REVIEW

Please answer the following yes or no questions. At the end of each section indicate onset, frequency, severity, treatment and other pertinent details. Answer every question.

### HEAD AND NERVOUS SYSTEM

Have you ever been subject to headaches/fatiness/dizziness/blackouts/convulsions? \_\_\_\_\_  
Do you have any phobias (fears)? \_\_\_\_\_ Do you have obsessions/compulsions? \_\_\_\_\_  
Do you have any difficulty with vision/hearing/noises in the ear? \_\_\_\_\_  
Are there times when you have trembling/shakiness/sweating/stammering/hysteria/chills/trouble sleeping? \_\_\_\_\_  
Have you ever had frequent colds/sinus trouble/running ears/earache/unusual fatigue? \_\_\_\_\_  
Do you have difficulty with poor appetite/overeating/bad or frightening dreams? \_\_\_\_\_  
Have you had a stroke? \_\_\_\_\_ Do you ever feel depressed? \_\_\_\_\_  
Have you ever felt suicidal? \_\_\_\_\_ Do you have a way to handle stress? \_\_\_\_\_  
Details: \_\_\_\_\_

### MUSCULO-SKELETAL

Have you ever been bothered by weak or painful feet/cold hands and feet even warm weather/frequent backaches? \_\_\_\_\_  
Have you ever had any twitching of the head, hands or shoulders/paralysis/neuritis/arthritis/numbness or tingling of a part of your body? \_\_\_\_\_  
Have you ever had injury to bone/joint/muscle/knee cartilage/head/severe sports injury/motor vehicle accident? \_\_\_\_\_  
Do you have a joint problem or weakness of any muscle? \_\_\_\_\_  
Details: \_\_\_\_\_

### HEART AND LUNGS

Have you been subject to a cough lasting more than one month/spitting up blood/swelling of ankles/high blood pressure/heart murmur? \_\_\_\_\_  
Are you now or have you been subject to shortness of breath/wheezing/palpitations/thumping of heart/pain in chest/heaviness in chest? \_\_\_\_\_ Have you had a heart attack? \_\_\_\_\_  
Details: \_\_\_\_\_

### DIGESTIVE SYSTEM

Have you ever been subject to vomiting blood, passing blood from rectum, black bowel movements, hemorrhoids, hernia? \_\_\_\_\_  
Other than symptoms related to influenza, have you ever had attacks of gassiness, indigestion, stomach pain, diarrhea, constipation, colitis, abdominal cramps, nausea, vomiting? \_\_\_\_\_  
Have you had a problem with bulimia, anorexia or compulsive overeating? \_\_\_\_\_  
Details: \_\_\_\_\_

### GENTO-URINARY

Do you have a problem with wetting the bed, starting or stopping urination? \_\_\_\_\_  
Have you ever had burning urination, getting up at night to urinate, blood in the urine, discharge from the bladder or genitalia, bladder, prostate, fallopian tube, kidney infection? \_\_\_\_\_  
Details: \_\_\_\_\_

### GENERAL

What over-the-counter or prescription drugs do you use? \_\_\_\_\_  
Describe your use of caffeine, tobacco, alcohol, illegal drugs of any kind: \_\_\_\_\_  
Are you subject to unpredictable wide swings of mood? \_\_\_\_\_  
Have you been absent from work due to illness in the past five years or from normal activity in case you are not employed? Yes \_\_\_\_\_ No \_\_\_\_\_ If this has already been covered, refer to the question where you answered it. If not, give detail: \_\_\_\_\_  
Have you ever received workman's compensation or disability payments? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_  
For how long? \_\_\_\_\_ For what? \_\_\_\_\_

### MENSTRUAL HISTORY

Age at onset \_\_\_\_\_ Interval between periods \_\_\_\_\_ Duration of period \_\_\_\_\_ days.  
Regular or irregular? \_\_\_\_\_ Date of last period \_\_\_\_\_ Describe current contraceptive use \_\_\_\_\_  
Amount - scant, moderate, profuse \_\_\_\_\_ Is PMS a problem? \_\_\_\_\_  
Are you bothered before menstruation by depression or irritability? \_\_\_\_\_  
Discomfort: none, slight, moderate, severe: \_\_\_\_\_  
Does your menstruation interfere with physical/social activities? Yes \_\_\_\_\_ No \_\_\_\_\_  
Are you subject to any bleeding or discharge between periods? Yes \_\_\_\_\_ No \_\_\_\_\_  
Have you had any C-sections, miscarriages, normal deliveries? Give dates, any complications \_\_\_\_\_

*I certify that I have answered the above questions fully and honestly and that there are no other significant health facts known to me.*

Signed \_\_\_\_\_ Date \_\_\_\_\_