Dr. Tolga Icli
Adult History Form

Name: _____ D.O.B. _____ Age: _____ Sex: ___Male ___Female
What name would you like to be called:_____Race:_____Religious Preference _____
Please Check One Single ___ Married ___ Divorced ___ Separated___ Widowed___
Whom do you currently live with? Alone ___ Family ____ Friends ___ Significant Other___
Dou you feel safe at home? YES NO
Current Job _____Previous Job _____ Highest Level of Education _____

MEDICATIONS (Please include all Prescriptions, over-the-counter, vitamins and supplements)

Name of Medication	**Dose**	**Reason for Taking**

Allergies to any Medications, X-ray Dies, Latex or other substances **YES** _____ **NO** _____

_____
_____
_____

Surgeries/Hospitalizations (Please list date and details. Circle appropriate category for each event)

Date	**Surg/Hosp**	**Reason/Details**
	Surg/Hosp	
	Surg/Hosp	
	Surg/Hosp	
	Surg/Hosp	
	Surg/Hosp	
	Surg/Hosp	

SEVERE INJURIES Please list dates and details of any injuries you have ever had.

_____
_____

IMMUNIZATIONS
Date of Last Tetanus Vaccine? _____
Date of Hepatitis B series? _____
Date of Last Pneumonia Vaccine _____
Date of Last TB Screening POS____NEG____
Date of Chicken Pox Disease or Shot _____
Date of Last Flu Vaccine _____
Date of Gardasil Series? _____

HEALTH MAINTENANCE
Date of your Last Colonoscopy? _____
Date of your Last Mammogram? _____
Date of your Last Eye Exam? _____
Date of your Last Pap Smear? _____
Date of your Last Bone Density test? _____
Date of Last Wellness Exam? _____
Do you consider yourself? Underweight _____ Normal weight _____ Overweight _____ Obese ____
What kind of exercise do you do? _____ How often? _____

Do you wear Seatbelts? YES ___ NO ___
Do you feel safe at Home? YES ___ NO ___
Do you drink Coffee/soda/tea? YES ___ NO ___
Do you use Sunscreen? YES ___ NO ___
Do you TEXT while Driving YES ___ NO ___
If YES, how many cups/cans a day? _____

What type of Birth Control is used between you and your Partner? _____

___Allergies
___Abnormal EKG
___Blood Transfusion
___Colitis
___Depression
___Emphysema/COPD
___Genital Herpes
___Heart Attack
___High Blood Pressure
___Hodgkin's
___Liver Disease
___Migraines
___Pneumonia
___Stroke
___Tuberculosis/Positive test

___Anemia
___Alcoholism
___Back Pain
___Concussion
___Dizziness
___Erectile Disfunction
___Gout
___Heart Murmur
___Hemorrhoids
___Insomnia
___Leukemia
___Muscle Disease
___Psoriasis
___Skin Disease

___Arthritis
___Acid Reflux
___Breast Lumps
___Cold Sores
___Diarrhea
___Epilepsy/Seizures
___Headaches
___Heart Disease
___Heart Failure
___Irritable Bowel
___Lung problems
___OCD
___Polio
___Sinus Disease
___Ulcer Disease

___Anxiety
___Blood Clots
___Cancer
___Constipation
___Drug Overdose/Abuse
___Glaucoma
___Hearing Problems
___Hepatitis
___High Cholesterol
___Kidney Disease
___Lupus
___Pancreatitis
___Sickle Cell Anemia
___Suicide Attempt
___Urinary infections

___Anemia
___Bleeding problems
___Chest pain
___Diabetes
___Eczema
___Gallbladder Disease
___Hernia
___Herniated Disk
___HIV/AIDS
___Kidney Stones
___Meningitis
___Panic Attacks
___STD _____
___Thyroid Disease
___Other _____

Family History – Please put a checkmark in all applicable boxes Were you adopted? Yes ___ No ___

Illness	Father	Mother	Sibling	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Heart Disease									
High Cholesterol									
High Blood Pressure									
Diabetes									
Heart Attack									
Stroke									
Kidney Disease									
Liver Disease									
Bleeding/Clotting Disorders									
Asthma									
Anemia									
Colon/Bowel Problems									
Breast Cancer									
Skin Cancer									
Prostate Cancer									
Lung Cancer									
Ovarian Cancer									
Other Cancer									
Glaucoma									
Thyroid Disease									
Drug/Alcohol Addiction									
Depression/Anxiety									
Suicide									
Seizures/Epilepsy									
HIV/AIDS									
Other:									

OB-GYN History

Age of First Menses _____ Date of last period _____ Do you suffer from PMS? YES _____ NO _____
Have you ever had Abnormal PAP? YES _____ NO _____ If YES, Date and Results. _____
Pregnancies: Total Number _____ Full Term _____ Miscarriages _____ Abortions _____Premature _____Tubal _____
Complications: _____

Social History

Are you Sexually Active? YES _____ NO _____ If YES, are your partners MEN _____ WOMEN _____BOTH_____
Have you ever had a sexually transmitted disease? YES _____ NO _____ Diagnosis: _____

Do You Smoke? YES ____ NO ____ How many per day? _____ Have you ever quit? YES_____ NO _____
Do you use other Tobacco Products? When? _____

Do you drink alcohol? YES____ NO ____ How many per day? _____ How many per week? _____
Have you ever had a problem with alcohol in your past? YES ___ NO _____ Explain? _____
Has anyone expressed concerns about your alcohol use? YES ___ NO ____ Explain? _____

Do you currently use any Recreational Drugs? Yes ____ NO ____ What types? _____
Have you ever had a drug problem in the past? (Prescription Drug Addiction or Illegal Drug use?) YES _____ NO _____
If Yes, Explain _____