MANGO Medical Clinic
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Form B: Adult Health History Form

Date_____

Your answers on this form will be kept confidential, and they will help your healthcare provider get an accurate history of your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Thank you!

A: DEMOGRAPHIC:

Last name	
First name	
Date of birth	
Gender	
Adddress	
Personal Health Number (PHN)	
Primary phone	
Secondary phone	
Email	
Emergency contact name	
Emergency contact number	

B: PAST MEDICAL HISTORY:

1. Where were you getting your care before?

2. What past medical issues do you have? (For example, diabetes, high blood pressure…)

3. Do you see any specialist doctors? Please list their name and specialty:

4. What surgeries have you had in the past? (For example, appendix, gall bladder, tonsil surgeries…)

5. What medications do you take? (Please attach complete list if more space is required)

Medication	Dosing	What for?

6. What allergies do you have?

7. Have you had the following tests? If so, when?

- Stool test for blood (FIT) □ No □ Yes, date:_____
- Colonoscopy □ No □ Yes, date:_____
- Mammograms* □ No □ Yes, date:_____
- Pap smears* □ No □ Yes, date:_____

*applies to female patients

Please comment on any abnormal results:

C: FAMILY HISTORY:

Do you have any family history of

- heart attack □ No □ Yes, who:_____
- diabetes □ No □ Yes, who:_____
- stroke □ No □ Yes, who:_____
- hip fractures □ No □ Yes, who:_____
- breast cancer □ No □ Yes, who:_____
- colon cancer □ No □ Yes, who:_____
- other cancers □ No □ Yes, who:_____
- thyroid problems □ No □ Yes, who:_____
- rheumatological issues □ No □ Yes, who:_____
- hepatitis □ No □ Yes, who:_____
- anxiety □ No □ Yes, who:_____
- depression □ No □ Yes, who:_____
- bipolar □ No □ Yes, who:_____
- schizophrenia □ No □ Yes, who:_____
- suicide □ No □ Yes, who:_____
- alcohol or substance abuse □ No □ Yes, who:_____
- Other significant medical issues in your family:

D: MENTAL HEALTH SCREENING:

1. In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? □ No □ Yes
2. Feeling down, depressed or hopeless? □ No □ Yes
3. Anxious, keyed up, or on edge? □ No □ Yes

E: SUBSTANCE USE HISTORY:

1. Do you smoke? □ No □ Yes, _____ packs a day for _____ years

   □ I quit in _____ (year) after smoking for _____ years

2. How many alcoholic beverages do you drink in a week? _____ drinks

3. Do you use recreational substances? □ No □ Yes

F: SOCIAL HISTORY:

1. Occupation (or prior occupation): _____
2. Are you: retired/unemployed/leave of absence/disabled/other: _____
3. Years of education or highest degree: _____
4. Are you on any forms of disability?
5. Do you have third party drug coverage?
6. Marital status (circle one): single, partner, married, divorced, widowed, other: _____
7. Who lives at home with you?
8. Do you have dietary restrictions?
9. Are you vegetarian?
10. Do you consider yourself to have a sedentary lifestyle?
11. Do you have any family members in our clinic? Who are they?

Do you have anything else you would like us to know about you?