FUNCTIONAL MEDICAL INSTITUTE **PHONE: 1-918-748-3640**
DR MICHELE L NEIL DO **FAX: 1-918-748-3644**
6048 S SHERIDAN ROAD TULSA, OK 74145

ADULT HISTORY FORM

PATIENT NAME: _____DATE OF BIRTH:_____
Pharmacy_____(Optional)

MEDICATIONS

Drug	Dose	Frequency	Reason

PATIENT ALLERGY:	TYPE OF REACTION

PATIENT PAST MEDICAL HISTORY (if any of the following apply please put date, age and comment)

	DATE	AGE	COMMENT, TYPE, ETC
Asthma			
Cancer			
Depression			
Diabetes			
Emphysema			
Hay Fever			
Heart Disease			
High Blood Pressure			
Stroke			
Thyroid			

PATIENT PAST SURGICAL HISTORY (if any of the following apply please put date, age and comment)

TYPE	DATE	AGE	COMMENT, TYPE, ETC.

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IMMUNIZATIONS: **PATIENT NAME:_____**

	RECEIVED	DATE (if Known)	COMMENT
Tetanus	YES/NO		
Pneumonia	YES/NO		
Hepatitis A	YES/NO		
Hepatitis B	YES/NO		
Influenza	YES/NO		
MMR	YES/NO		
other	YES/NO		

FAMILY HISTORY:

	AGE	CIRCLE STATE OF HEALTH				
MOTHER		Excellent	Good	Fair	Poor	Deceased
FATHER		Excellent	Good	Fair	Poor	Deceased

Do you have a first degree relative (Parent, Brother, Sister, Child**) with any of the following?**

	YES	NO	Who/What relation
Alcoholism			
Breast Cancer			
Colon Cancer			
Diabetes			
Drug Abuse			
Heart Attack			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Mental Illness			
Prostate Cancer			
Stroke			
Other Cancer/Type			
Other			
Other			

SOCIAL HISTORY:

Marital Status	Single Married Separated Divorced Widowed Other
Lives With	Self Spouse Children Family Partner Parents Life Partner
# Kids	
HAS ANYONE IN THE ENVIRONMENT EVER THREATENED TO HURT YOU	YES/NO
OCCUPATION	
DO YOU HAVE AN ADVANCED DIRECTIVE(LIVING WILL)?	YES/NO
ARE YOU A "DO NOT RESUSCITATE" PATIENT	YES/NO

TOBACCO USE : Y/N Quit date_____ Type_____Amount_____ Length of Time_____