Cigna

Adult Medical History

CLEAR FORM

COMPLETED BY MEMBER

Date: _____ MRN#: _____

Name of Member: _____ Date of Birth: _____ Gender: ☐ M ☐ F
Last Name First Name M.I.

Member Street Address: _____
Street Apt # City State Zip Code

Occupation: _____ ☐ Unemployed ☐ Student Member Phone Number: _____

Employer's Name: _____ Home Phone Number: _____ Work Phone Number: _____

Employer's Address: _____
Street Suite # City State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow / Windower

PAST ILLNESSES: Please check ALL that apply.

☐ Allergies	☐ Diabetes	☐ High Blood Pressure	☐ Mental Illness	☐ Other:
☐ Anemia	☐ High Cholesterol	☐ Injury / Fracture	☐ Siezures	
☐ Arthritis	☐ Heart Problems	☐ Kidney Disease	☐ Skin Problems	
☐ Cancer	☐ Hepatitis	☐ Lung Problems	☐ Ulcer Diseases	

Explanation: _____

Current Medications & Dosage:

_____

_____

_____

Medication Allergies: ☐ None _____

PAST SURGERIES:

YEAR	PROCEDURES

PAST HOSPITALIZATIONS:

YEAR	DIAGNOSIS	WHICH HOSPITAL

FAMILY HISTORY:	Alcoholism	Asthma	Cancer (Type)	Depression	Diabetes	Heart Disease	High Blood Pressure	Stroke	Cause of Death	Age at Death
Father	☐	☐		☐	☐	☐	☐	☐		
Mother	☐	☐		☐	☐	☐	☐	☐		
Brothers/Sisters	☐	☐		☐	☐	☐	☐	☐		
Grandparents	☐	☐		☐	☐	☐	☐	☐		

SOCIAL HISTORY

Tobacco: ☐ None ☐ Chew Tobacco ☐ Cigarettes _____ # cigarettes/day ☐ Cigar Quit Date: _____

Alcohol: ☐ None Drinks/week: _____ Type of drink: _____ ☐ Other drug use: (cocaine, marijuana, etc.) _____

Daily Exercise: ☐ None ☐ Low ☐ Moderate ☐ High → ☐ Aerobic Activity ☐ Weight Training

Seat Belt Use: ☐ Yes ☐ No ☐ Child Safety Restraints (car seats) used for child < 40lbs or types of age.

IMMUNIZATIONS (Most Recent)

Tetanus: _____ Hepatitis B: _____ Pneumovax: _____ Flu Vaccine: _____

SCREENING EXAMS (Most Recent)

Pap smear: _____ Mammogram: _____ Cholesterol: _____ Sigmoid/Colonoscopy: _____

Clinician's Signature:
X _____

Member's Signature:
X _____