ADULT MEDICAL SERVIES PC
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_____

Name DOB Date

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all six pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank You!

Main reason for today's visit: _____
Other concerns: _____
What are your health goals for the next year?:_____
Where were you getting your care before?:_____

Review of symptoms: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you.

**General**
__Unexplained weight loss/gain
__Unexplained fatigue/weakness
__ Fall asleep during the day when sitting
__Fever, chills
__ No problems

**Skin**
__ New or change in mole
__ Rash/itching
__ No problems

**Breast**
__ Breast lump/pain/nipple discharge
__ No problems

**Ears/Nose/Throat**
__ Nosebleeds,trouble swallowing
__ Frequent sore throat,hoarseness
__ Hearing loss/ringing in ears
__ No problems

**Eyes**
__ Change in vision/eye pain/

**Cardiovascular**
__ Chest pain/discomfort
__ Palpitations (fast or irregular heartbeat)
__ No problems

**Respiratory**
__ Cough/wheeze
__ Loud snoring/altered breathing during sleep
__ Short of breath with exertion
__ No problems

**Gastrointestinal**
__ Heartburn/reflux/indigestion
__ Blood or change in bowel movement
__ Constipation
__ No problems

**Genitourinary**
__ Leaking urine
__ Blood in urine
__ Nighttime urination or increased frequency
__ Discharged: penis or vagina
__ Concern with sexual frustration
__ No problems

**Musculoskeletal**
__ Neck pain
__ Back pain
__Muscle/joint pain
__ No problems

**Endocrine**
__ Heat or cold sensitivity
__ No problems

**Hematologic/Lymphatic**
__ Swollen glands
__ Easy bruising
__ No problems

**Neurological**
__ Headache
__ Memory loss
__ Fainting
__ Dizziness
__ Numbness/tingling
__ Unsteady gait
__ Frequent falls
__ No problems

**Allergic/Immune**
__ Hay fever/allergies
__ Frequent infections
__ No problems

**Psychiatric**
__ Anxiety/stress/irritability
__ Sleep problem
__ Lack of concentration
__ No problems

**Women Only**
__ Pre-menstrual symptoms (bloating,cramps,irritability)
__ Problem with menstral periods
__ Hot flashes/night sweats
__ No problems

**IMMUNIZATIONS:** Check off any vaccinations you have had. Add year, if known.

Tetanus(Td)_____ With Pertussis(Tdap)_____ Varicella(Chicken Pox) shot or illness_____ Pneumovax(pneumonia)_____ Influenza(flu shot)_____ Hepatitis A_____ Hepatitis B_____ MMR_____ Meningitis_____ Zostavax(shingles)_____ HPV_____

**MEDICATIONS:** Please list (or attach your own printed record) of all prescription and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

□ **TAKE NO MEDICATIONS**

Medication Dose(e.g mg/pill) How many times per day?

_____

_____

_____

_____

_____

_____

Allergies or intolerance to medications (include type of reaction):_____

_____□**NONE**

**HEALTH MAINTENANCE SCREENING TESTS:**

| | | | | |
|---|---|---|---|---|
| Lipid(cholesterol) | Date_____ | Abnormal? | □ No | □ Yes |
| Sigmoidoscopy: | Date_____ | Abnormal? | □ No | □ Yes |
| Colonoscopy: | Date_____ | Abnormal? | □ No | □ Yes |
| Women only: | | | | |
| Mammogram | Date_____ | Abnormal? | □ No | □ Yes |
| Pap Smear | Date_____ | Abnormal? | □ No | □ Yes |
| Bone Density Test | Date_____ | Abnormal? | □ No | □ Yes |

**SOCIAL HISTORY**

Occupation(or prior occupation):_____retired/unemployed/leave of absence/disabled (circle one)
Employer:_____Years of education or highest degree:_____
Marital Status(circle one): Single/Partner/Married/Divorced/Widowed/Other:_____
Spouse/Partner's Name:_____Number of Children____Ages if under 18_____
Number of Grandchildren:_____ Number of Great Granchildren:_____
Who Lives at Home with You?:_____
Leisure activities, group involvement, religion, volunteer work, recent travel:_____
_____
_____

**WOMEN'S HEALTH HISTORY**

Total number of pregnancies:_____ Number of births:_____
Date(Month/Day if known) of last menstrual period(if still menstruating):_____
Age you started menstruating:_____ Age you stopped menstruating(menopause):_____

**OTHER HEALTH ISSUES**

**Tobacco Use:**
Smoke Cigarettes: □ Yes □ Quit □ Never
Quit Date:_____
How many years did you smoke?_____
Approx. how many packs a day did you smoke?_____
Current Smoker: Packs/Day:____ # of years:_____
Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

**Alcohol Use:**
Do you drink alcohol? □ Yes □ No
# of Drinks/Week:_____ □ Beer □ Wine □ Liquor

**Drug Use:**

Do you use marijuana or recreational drugs? □ Yes □ No
Have you ever used needles to inject drugs? □ Yes □ No

**Sexual Activity:**

Sexually Active? □ Yes □ No
Sexual partner(s) is/are/have been: □ Male □ Female
Birth Control Method(circle below all that apply):
Condom, Pill, Diaphragm, Vasectomy, Other:_____
□ None Needed

**Exercise:**
Do you exercise regularly? □ Yes □ No
What kind of exercise?
_____
_____
_____
_____
How long(minutes)?_____
How often?_____

**Diet:**
How would you rate your diet? □ Good □ Fair □ Poor
Would you like advice on your diet? □ Yes □ No

**Saftey:**
Do you use a bike helmet? □ No Bike □ Yes □ No
Do you use seatbelts consistently? □ Yes □ No
Does your home have a working smoke detector? □ Yes □ No

If you have guns in your home, are they locked up properly? □ Not Applicable □ Yes □ No
Is violence at home a concern for you? □ Yes □ No

Have you completed an Advance Directive for Health Care(ADHC), Living Will, or POLST(Physician Orders for Life Sustaining Therapy)? (Circle all that apply) □ No

**PERSONAL MEDICAL HISTORY:** Do you have now or have you had any of the following conditions? □ **NONE**

| CONDITION | CURRENT | PAST | COMMENTS |
|---|---|---|---|
| Alcohol/Drug Abuse | | | |
| Allergy (Hay Fever) | | | |
| Anemia | | | |
| Anxiety | | | |
| Arthritis (Rheumatoid) | | | |
| Arthritis (Osteoarthritis) | | | |
| Asthma | | | |
| Bladder/Kidney Problems | | | |
| Blood-Clot (Leg) | | | |
| Blood-Clot (Lung) | | | |
| Blood Transfusion | | | |
| Breast Lump (Benign) | | | |

| Cancer Breast | | | |
|---|---|---|---|
| **PERSONAL MEDICAL HISTORY CONT.**<br>**Condition** | **Current** | **Past** | **Comments** |
| Cancer Colon | | | |
| Cancer Ovarian | | | |
| Cancer Prostate | | | |
| Cancer (Other Type) | | | |
| Cataracts | | | |
| Chicken Pox | | | |
| Colon Polyp | | | |
| Coronary Artery Disease | | | |
| Depression | | | |
| Diabetes (Adult Onset) | | | |
| Diabetes (Childhood Onset) | | | |
| Diverticulosis | | | |
| Emphysema | | | |
| Fractures (Broken Bones) | | | |
| Gallbladder Disease | | | |
| Gastroesophageal Reflux (Heartburn/GERD) | | | |
| Glaucoma | | | |
| Gout | | | |
| Gynecological Conditions | | | |
| Heart Attack | | | |
| Hepatitis – Type A | | | |
| Hepatitis- Type B | | | |
| Hepatitis – Type C | | | |
| Hepatitis – Other | | | |
| High Blood Pressure | | | |
| High Cholestrerol | | | |
| Hip Fracture | | | |
| Irritable Bowel Syndrome | | | |
| Kidney Disease/Failure | | | |
| Kidney Stones | | | |
| Liver Disease | | | |
| Migraine Headaches | | | |
| Osteoporosis | | | |
| Pneumonia | | | |
| Prostate (Enlargement) | | | |
| Prostate (Nodules) | | | |
| Seizure/Epilepsy | | | |
| Skin Condition | | | |
| Sleep Apnea | | | |
| Stomach Ulcer | | | |
| Stroke | | | |
| Thyroid (Nodule) | | | |
| Thyroid High (Overactive)/Hyperthyroidism | | | |
| Thyroid Low (Underactive) Hypothyroidism | | | |
| Other (List) | | | |

**SURGICAL HISTORY –** Please check off any procedure or surgeries. List any abnormal findings or complications □ **NONE**

| Surgical Procedure | Yes | Year | Comments |
|---|---|---|---|
| Abdominal Surgery | | | |
| Appendectomy (Appendix Removal) | | | |
| Back Surgery (Lumbar) | | | |
| Biopsy (Location) | | | |
| Breast Biopsy | | | Circle: Right Left Both |
| Breast Surgery | | | Circle: Right Left Both |
| Colonoscopy | | | |
| Coronary Bypass | | | |
| Coronary Stent | | | |
| EGD (Stomach Endoscopy) | | | |
| Cataract | | | |
| Gallbladder Removal | | | Circle: Laparoscopic |
| Heart Surgery (Other than Coronary Bypass) | | | |
| Hip Surgery | | | Circle: Right Left Both |
| Hysterectomy (Total Including Ovaries) | | | Circle: Laparoscopic Vaginal Abdominal |
| Hysterectomy (Partial, Ovaries Left) | | | Circle: Laparoscopic Vaginal Abdominal |
| Knee Surgery | | | Circle: Right Left Both |
| LEEP (Cervix Surgery) | | | |
| Neck Surgery | | | |
| Ovary Ligation (“Tubal”) | | | |
| Ovary Removal | | | Circle: Right Left Both |
| Vasectomy | | | |
| Sigmoidscopy | | | |
| Sinus Surgery | | | |
| Other (List) | | | |

Adopted – □ Yes □ No (please circle) If yes and you do not know your family history skip this section.

**FAMILY HISTORY**-Indicate which relative has had the following diseases (parents and siblings are most important)

| Disease | Mother | Father | Sister(s) | Brother(s) | Mom's Mom | Mom's Dad | Dad's Mom | Dad's Dad | Other Relative | Comments |
|---|---|---|---|---|---|---|---|---|---|---|
| **No Significant History** | | | | | | | | | | |
| Alcoholism/Drug Abuse | | | | | | | | | | |
| Alzheimers | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Autouimmune Disease | | | | | | | | | | |
| Bleeding or Clotting Disorder | | | | | | | | | | |
| Cancer Breast | | | | | | | | | | |
| Cancer Colon | | | | | | | | | | |
| Cancer Ovarian | | | | | | | | | | |
| Cancer Prostate | | | | | | | | | | |
| Cancer (Other Type) | | | | | | | | | | |
| Colon Polyp | | | | | | | | | | |
| Coronary Artery Disease | | | | | | | | | | |
| Depression/Suicide/Anxiety | | | | | | | | | | |
| Diabetes (Adult Onset) | | | | | | | | | | |
| Diabetes (Childhood Onset) | | | | | | | | | | |
| Emphysema (COPD) | | | | | | | | | | |
| Genetic Disorder (Explain) | | | | | | | | | | |
| Glaucoma | | | | | | | | | | |
| Heart Disease (CHF) | | | | | | | | | | |
| Heart Disease (Other) | | | | | | | | | | |
| Hepatitis B or C | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | |
| Hip Fracture | | | | | | | | | | |
| Thyroid Disease | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | |
| Kidney Stones | | | | | | | | | | |
| Macular Degeneration | | | | | | | | | | |
| Migraine Headaches | | | | | | | | | | |
| Osteoporosis | | | | | | | | | | |
| Other (List) | | | | | | | | | | |