# FAMILY DOC'S CLINIC

Patient Name _____

Birthdate _____

**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. If you are a current patient there is a shorter update form you can use. Please fill in all five 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?**_____

In the past **2 weeks**, have you been bothered by: Little interest or pleasure in doing things? ☐ **No** ☐ **Yes**

Feeling down, depressed or hopeless? ☐ **No** ☐ **Yes**

**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. List other concerns above.

*General*
___ Unexplained weight loss / gain
___ Unexplained fatigue / weakness
___ Fall asleep during 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 / redness
___ **No problems**

*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
___ Discharge: penis or vagina
___ Concern with sexual function
___ **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 menstrual periods
___ Hot flashes / night sweats
___ **No problems**

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## MEDICATIONS

*List any medications you take, prescription, and their dosage:*

☐ No Medications

| | Medication | Dose |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

## ALLERGIES & REACTIONS

*Please list any significant reactions you have to medications and/or foods:*

☐ No Allergies/Reactions

**Medication**

☐ Asprin _____

☐ Penicillin _____

☐ Sulfa _____

☐ Others _____

_____

_____

_____

**Substance**

☐ Latex _____

☐ IV Contrast _____

☐ Insect Stings _____

☐ Food Reactions _____

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**IMMUNIZATIONS:** Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐

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 _____

**SOCIAL HISTORY:** Check off any areas that apply.

- ☐ Live alone
- ☐ Pets
- ☐ Employed
- ☐ Receive disability payments

Abuse & Violence

- ☐ Abused
  - ○ Mentally
  - ○ Physically
  - ○ Sexually
  - ○ Verbally
- ☐ At risk for violence
- ☐ At risk for violence in the home

Safety

- ☐ Seat belt use
- ☐ Helmet worn

Diet & Exercise

- ☐ Exercises
- ☐ Follows a diet
- ☐ Caffeine

Sexual Activity

- ☐ Sexually active
- ☐ More than one sexual partner in the last year
- ☐ Sexual relations with someone who had a blood transfusion
- ☐ Sexual relations with someone who used intravenous drugs
- ☐ Sexual relations with someone who is homosexual or bisexual

Tobacco/Alcohol/Drug Use

- ☐ Never smoked
- ☐ Former smoker
- ☐ Current every day smoker
- ☐ Current occasional smoker
- ☐ Passive smoker
- ☐ Light tobacco smoker (less than 10 cigarettes per day)
- ☐ Heavy tobacco smoker (greater than or equal to 10 cigarettes per day)
- ☐ Other tobacco use
- ☐ Alcohol use
- ☐ Past drug use
- ☐ Current drug use

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**SURGICAL HISTORY** – Please check off any procedure or surgeries. Add year, if known. ☐ **NONE**

- ☐ Angioplasty-heart balloon_____
- ☐ Angioplasty with stent_____
- ☐ Aortic valve replacement_____
- ☐ Appendectomy_____
- ☐ Back surgery_____
- ☐ Bladder surgery_____
- ☐ Bone fracture (pins &/or plates)_____
- ☐ Bunionectomy_____
- ☐ Cardiac pacemaker_____
- ☐ Carpal tunnel release_____
- ☐ Cataract extraction_____
- ☐ Cholecystectomy_____
- ☐ Colectomy_____
- ☐ Coronary artery bypass graft____
- ☐ Deviated septum repair_____
- ☐ Gallbladder_____
- ☐ Gastric bypass_____
- ☐ Hemorhoidectomy_____
- ☐ Hernia repair_____
- ☐ Lasik_____
- ☐ Lens implants_____
- ☐ Lobectomy_____
- ☐ Liver biopsy_____
- ☐ Mitral valve replacement_____
- ☐ Myringotomy and insertion of T tube_____
- ☐ Thyroid cysts, aspiration_____
- ☐ Thyroidectomy_____
- ☐ Tonsillectomy_____
- ☐ Total hip replacement_____
- ☐ Total knee replacement_____
- ☐ Trigger finger release_____
- ☐ Other (list)_____

**MEN'S SURGICAL HISTORY** – Please check off any procedure or surgeries. Add year, if known. ☐ **NONE**

- ☐ Vasectomy_____
- ☐ Prostate biopsy_____
- ☐ Prostate surgery_____
- ☐ TURP (Trans-Urethral Resection of Prostate)_____
- ☐ Other (list)_____

**WOMEN'S SURGICAL HISTORY** – Please check off any procedure or surgeries. Add year, if known. ☐ **NONE**

- ☐ Breast biopsy_____
- ☐ Cesarean section_____
- ☐ Dilation and curettage_____
- ☐ Hysterectomy partial removal of cervix and uterus_____
- ☐ Hysterectomy total with removal of both tubes and ovaries_____
- ☐ Lumpectomy of breast_____
- ☐ Ovarian cyst removal_____
- ☐ Tubal ligation_____
- ☐ Unilateral mastectomy_____
- ☐ Other (list)_____

**WOMEN'S HEALTH HISTORY:**

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of periods (menstruation): _____ Age at end of periods (menopause): _____

Total number of pregnancies: _____ Number of births: _____

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**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 known** | | | | | | | | | | |
| Alcoholism / Drug abuse | | | | | | | | | | |
| Alzheimer's | | | | | | | | | | |
| Anemia | | | | | | | | | | |
| Arthritis | | | | | | | | | | |
| Asthma | | | | | | | | | | |
| Autoimmune Disease | | | | | | | | | | |
| Bleeding or Clotting Disorder | | | | | | | | | | |
| Cancer Breast | | | | | | | | | | |
| Cancer Colon | | | | | | | | | | |
| Cancer Other Type | | | | | | | | | | |
| Cancer Ovarian | | | | | | | | | | |
| Cancer Prostate | | | | | | | | | | |
| Cancer Uterus | | | | | | | | | | |
| Cerebral Vascular Accident (stroke) | | | | | | | | | | |
| Colon Polyp | | | | | | | | | | |
| Coronary Artery Disease (e.g. heart attack, angina) | | | | | | | | | | |
| Depression / Suicide / Anxiety | | | | | | | | | | |
| Diabetes (childhood onset) | | | | | | | | | | |
| Diabetes (adult onset) | | | | | | | | | | |
| DVT | | | | | | | | | | |
| Emphysema (COPD) | | | | | | | | | | |
| Genetic Disorder (explain) | | | | | | | | | | |
| Glaucoma | | | | | | | | | | |
| Heart Disease (CHF) | | | | | | | | | | |
| Heart Disease (Other) | | | | | | | | | | |
| Hepatitis B or C | | | | | | | | | | |
| High Blood Pressure - Hypertension | | | | | | | | | | |
| High Cholesterol | | | | | | | | | | |
| Hip Fracture | | | | | | | | | | |
| Hypothyroidism / Thyroid Disease | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | |
| Kidney Stones | | | | | | | | | | |
| Macular Degeneration | | | | | | | | | | |
| Migraine Headaches | | | | | | | | | | |
| Osteoporosis | | | | | | | | | | |
| Other (list) | | | | | | | | | | |