Adult History (15+)

Name	DOB	Age	Gender

PROVIDENCE Medical Group Bridgeport

What Concerns do you have about your health that you want to discuss today?

Has patient ever had: (circle all that Apply)

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Pyschiatric
Asthma	Elipesy	High Cholesterol	Seasonal Allergies
Cancer	Heart disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes	Other:		

General Health Questions. (please circle any you've had over the last 3 months)

General: Fever, chills, weight loss/gian, night sweats
Eyes: vision loss, eye pain, discharge
ENT: ear ache, hearing loss, sore throat, congestion
Heart: chest pain, palpitations, swollen legs
Hematologic: easy bruising, enlarged lymph nodes
Skin: rash, itching, changing skin lesions
Pelvic: Decreased libido, irregular bleeding, pain with intercourse
Urinary: pain with urination, frequent urination, incontinece, blood in urine
GI: Nausea, vomiting, diarrhea/constipation, blood in stool, heartburn
Neuro: headache, dizziness, numbness, seizures, memory loss
Psych: Depression, anxiety, insomnia
Lung: cough, shortness of breath, wheezing
Skin: Rash, changing in skin lesions
Endocrine: Excessive thirst, cold or hot intolerance

Family History:	Age(s)	Living?	Age at Death	Medical Problems
Father	_____	**Y/N**	_____	_____
Mother	_____	**Y/N**	_____	_____
Brothers	_____	**Y/N**	_____	_____
Sisters	_____	**Y/N**	_____	_____
Child(ren)	_____	**Y/N**	_____	_____
Maternal Grandmother	_____	**Y/N**	_____	_____
Maternal Grandfather	_____	**Y/N**	_____	_____
Paternal Grandmother	_____	**Y/N**	_____	_____
Paternal Grandfather	_____	**Y/N**	_____	_____

Please list all surgeries:

Surgery/Year

Surgery/Year

Please list all medication allergies:

Please list all medications you are currently taking: (Medication/Dose/Frequency)

Dates of your last:

Physical exam: _____

Blood test/cholesterol level: _____

Colonoscopy/sigmoidoscopy: _____

Tetanus booster: _____

Pneumovax: _____

Mammogram: _____

Pap Smear: _____

Social History

Occupation: _____ Who lives with you?: _____

Spouse/partner's Name: _____ Marital Satus: S_____ M:_____ D:_____ W:_____ Other:_____

Health/Safety History

Cigarettes: Never :_____Quit:_____Date:_____

Packs/day:_____ # of years:_____

Other tobacco: Pipe:___Cigar:___Snuff:___Chew:__

Are you interested in quitting? Yes:_____No:_____

Diet:

Are you satisfied with your weight? Yes:_____ No:_____

How do you rate your diet? Good:____Fair:____Poor:_____

Alcohol use: Yes:____No:____ #drinks/week:_____

Are you or anyone else concerned about Your alcohol use? Yes:_____No:_____

Drug Use: Have you even used recreational drugs? Yes:_____No:_____ In the last month?_____

Exercise: Do you exercise regularly? Yes:_____No:_____

What Kind of exercise?_____

Sexual Activity: have you ever had sex? Yes:__No:__

Are you currently sexually active? Yes:____No:____

Sexual partner(s) is/are:___Male___female___both

Birth control method:_____None:____

Have you ever had any sexually transmitted diseases (STDs)? Yes:_____No:_____

Are you interested in being screened for sexually transmitted diseases? Yes:_____No:_____

How long (minutes)_____ How often?_____

Safety:

Do you use a bike helmet? Y/N

Use seatbelts consistently? Y/N

Smoke detector in home? Y/N

Fire extinguisher in home? Y/N

Have you been hit, kicked, punched or otherwise hurt by someone within the past year? Y/N

Is there a partner from a previous relationship who is making you feel unsafe now? Y/N