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ADULT HISTORY (18+)

NAME:	DATE OF BIRTH:	AGE:	Today's DATE:

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

Past Medical History:	**Date of Onset:**	**Resolved**

Surgery History	**Year**	**Any Complications?**

Medications

Medication	Dose	How many times per day?	When Started?

Any Known Drug Allergies? ☐ YES (Please list) ☐ NO

_____ _____

GENERAL HEALTH QUESTIONS: (Please indicate any you've had over the last 3 months)

☐ Skin Rashes ☐ Dizziness ☐ Frequent or severe headaches ☐ Seizures
☐ Eye problems ☐ Ear problems ☐ Difficulty swallowing ☐ Sinus problems
☐ Frequent coughing ☐ Trouble breathing ☐ Wheezing ☐ Lots of fevers
☐ Chest Pains ☐ High Blood Pressure ☐ Swollen Legs ☐ Sexual Problems
☐ Nausea ☐ Vomiting ☐ Stomach pains ☐ Diarrhea/Constipation
☐ Blood in stool ☐ Problems urinating ☐ Feel like you are constantly going to the bathroom to urinate
☐ Always feel thirsty ☐ Depressed ☐ Worried or Anxious ☐ Trouble controlling anger
☐ Weight change of ±15 lbs or more ☐ Arthritis pain ☐ Trouble walking
☐ Trouble sleeping ☐ Increased bruising/bleeding compared to what you are used to?

IMMUNIZATION HISTORY

- ☐ Tetanus? _____
- ☐ Td (Tetanus-Diptheria)? _____
- ☐ Tdap (Tetanus-Diptheria-Pertusis)? _____
- ☐ MMR (measles, mumps, Rubella)? _____
- ☐ Hepatitis A: #1_____ #2_____
- ☐ Hepatitis B: #1_____ #2_____ #3_____
- ☐ HPV (Gardasil)? _____
- ☐ Flu Shot? _____
- ☐ Pneumovax? _____
- ☐ TB Skin Test? _____
- ☐ HIV/AIDS Test? _____
- ☐ Chicken Pox (Varicella)? _____
- ☐ Zostavax (shingles)? _____

FOR WOMEN ONLY:

Last Pap Test?_____ Results _____ Last Mammogram?_____ Results _____

Have you EVER had a Pap Test or Mammogram that wasn't normal? ☐YES ☐NO

Pregnancies:_____ # Deliveries:_____ # Abortions:_____ # Miscarriages:_____

1st day of your most recent period: _____ Age @ 1st Period_____ ☐ Regular OR ☐Irregular

Do you have any concerns about your periods? ☐ YES _____ ☐ NO

Do you have any concerns about menopause? ☐ YES _____ ☐ NO

GENERAL HISTORY:

Occupation:_____ Employer:_____

Years of Education / Highest Degree_____ Marital Status: ☐S ☐M ☐D ☐W ☐Other_____

Spouse/Partner's Name:_____ Number of Children/Ages:_____

Who lives at home with you?_____

When was the last time you were **seen by a primary care doctor**? _____

Who did you see? _____

Do you have an **Advanced Directive** or **Living Will?** ☐Yes ☐No

Do you have a **POLST** (Physician Order for Life Sustaining Treatment)? ☐Yes ☐No

Please bring Advanced Directive, Living Will, and/or POLST to your appointment.

Have you had a Colonoscopy? ☐Yes ☐No **Date and results?** _____

FAMILY HISTORY: Please indicate the current status of your immediate family members:

	Alive	Deceased	Age (now or at death)	Comments / Medical Problems
Mother	☐	☐		
Father	☐	☐		
Sister(s) #____	☐	☐		
Brother(s) #____	☐	☐		

SOCIAL HISTORY:

TOBACCO Use:

Cigarettes: ☐ **Y** ☐ **N** ☐ **NEVER**

Quit? ☐/ Date_____

☐ Current Smoker: packs/day_____ # years_____

Other Tobacco: ☐Pipe ☐Cigar ☐Snuff ☐Chew

Are you interested in Quitting? ☐ **Y** ☐ **N**

ALCOHOL Use:

Do you drink Alcohol? ☐ **Y** ☐ **N** #drinks/Week_____

Are you or anyone else concerned about your alcohol use? ☐ **Y** ☐ **N**

DRUG Use:

Have you ever used recreational drugs? ☐ **Y** ☐ **N**

SEXUAL Activity:

Have you ever had sex? ☐ **Y** ☐ **N**

Current sex partner(s) is/are: ☐ **Male** ☐ **Female**

Birth Control Method: _____ ☐ None needed

Have you ever had any sexually transmitted diseases (STD's)? ☐ **Y** ☐ **N**

Are you interested in being screened for sexually transmitted diseases? ☐ **Y** ☐ **N**

CAFFEINE Intake:

☐None ☐Coffee/Tea: cups/day_____

Sodas/day_____ Chocolate/day_____

WEIGHT:

Are you satisfied with your weight? ☐ **Y** ☐ **N**

DIET:

How do you rate your diet? ☐Good ☐Fair ☐Poor

Do you take Supplements?_____

Do you drink 4 large glasses of milk daily or take calcium supplements? ☐ **Y** ☐ **N**

EXERCISE / SAFETY:

Do you exercise regularly? ☐ **Y** ☐ **N**

What kind of exercise? _____

How long (minutes)? _____ How often?_____

BIKE HELMET: do you use one? ☐ **Y** ☐ **N**

Use **SEATBELTS** consistently? ☐ **Y** ☐ **N**

Is **VIOLENCE** at home a concern? ☐ **Y** ☐ **N**

Have you been hit, kicked, punched or otherwise hurt by someone in the past year? ☐ **Y** ☐ **N**

Do you feel **unsafe** in your current relationship? ☐ **Y** ☐ **N**

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

Do you have a **gun** in your home? ☐ **Y** ☐ **N**