Providence Medical Group Southeast

Adult History (18+)

| Name | Date of Birth | | 1 | Age | Date |
|----------------------------|----------------------------|--------------------|------------|--------------------|--------------|
| | | | | | |
| | | | | | |
| What concerns do you ha | ive about your health that | t you want to | discuss to | oday? | |
| | | | | | |
| | | | | | |
| Do you have any major m | nedical illnesses: Yes | No Ple | ease list: | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Have you been hospitalize | ed overnight in the past y | ear? Yes | -No | Please list rea | sons: |
| | | | | | |
| | | | | | |
| | | | | | |
| Have you had any surgeri | es? Yes No | Please list: | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Are you currently taking a | any medications: Yes | No P | lease list | :: | |
| Medication | Dose | | How n | nany times per day | When started |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Do you have any drug alle | ergies Yes No | Please list: | | | |
| | | | | | |
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General Health Questions: (please circle any you've had over the last 3 months

| Skin rashes | Frequent or severe headaches | Seizures |
|---------------------|---|---------------------------|
| Dizziness | Ear problems | Difficulty swallowing |
| Eye problems | Trouble breathing | Wheezing |
| Frequent coughing | High Blood Pressure | Swollen legs |
| Chest pains | Stomach pains | Diarrhea |
| Nausea or vomiting | Feel like you are constantly going to the bathroom to urinate (pee) | Constipation |
| Problems urinating | A change of 15 lbs or more in your weight | Trouble walking |
| Always feel thirsty | Pain | Trouble controlling anger |
| Arthritis | Worried or anxious | Sexual problems |
| Depressed | Increased bruising/bleeding compared to what you are used to? | Trouble sleeping |
| Sinus problems | Lots of fevers | Blood in stool |

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| When was your last Pap test? When was your last mammogram? |
|--|
| Have you EVER had a Pap test or Mammogram that wasn't normal? Yes No |
| # Pregnancies # deliveries # abortions # miscarriages |
| 1 st day, most recent period Age at 1 st period Regular or Irregular |
| Do you have any concerns about your periods? Yes No |
| Do you have any concerns about menopause? Yes No |

Social 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? | | | | |

Family History

Please indicate the current status of your immediate family members:

| | | Alive | Deceased | Age (now or at death) | Comments/Cause of Death |
|------------|---|-------|----------|-----------------------|-------------------------|
| Mother | | | | | |
| Father | | | | | |
| Sister(s) | # | | | | |
| Brother(s) | # | | | | |

Health/Safety History

| Tobacco Use | CAFFEINE Intake: None Coffee Tea Cups/day | | |
|---|--|--|--|
| Cigarettes Never Quit: Date | # sodas/day Chocolate oz/day | | |
| Current Smoker packs/day # of years | WEIGHT: Are you satisfied with your weight? Yes No | | |
| Other tobacco: Pipe Cigar Snuff Chew | DIET: How do you rate your diet? Good Fair Poor | | |
| Are you interested in quitting? Yes No | Do you take SUPPLEMENTS? | | |
| Alcohol Use | Do you drink 4 lg glasses of milk daily or take CALCIUM | | |
| | supplements? Yes No | | |
| Do you drink alcohol? Yes No # drinks/week | EXERCISE: Do you exercise regularly? Yes No | | |
| Are you or anyone else concerned about your alcohol | What kind of exerciser? | | |
| use? Yes No | | | |
| <u>Drug Use</u> | How long? (minutes) How often? | | |
| Have you ever used recreational drugs? Yes No | BIKE HELMET Do you wear a bike helmet? Yes No | | |
| Sexual Activity | SEAT BELT: use seatbelts consistently? Yes No | | |
| Have you ever had sex? Yes No | Is VIOLENCE at home a concern for you? Yes No | | |
| Current sex partner(s) is/are: Male Female | Have you been hit, kicked, punched, or otherwise hurt by | | |
| | someone within the past year? Yes No | | |
| Birth control method: None needed | Do you feel safe in your current relationship/ Yes No | | |
| Have you ever had any sexually transmitted diseases | Is there a partner from a previous relationship who is | | |
| (STDs)? Yes No | making you feel unsafe now? Yes No | | |
| Are you interested in being screened for sexually | Do you have a GUN in your home? Yes No | | |
| transmitted diseases? Yes No | | | |