Arrow
FAMILY MEDICINE

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ADULT PATIENT HISTORY

Patients Name: _____ **DOB:** _____ **Today's Date:** _____

For what reason are you here today? _____

_____

Circle the last time you felt physically well: presently 6 months ago when I was a child other _____

Circle any you would like to change in your lifestyle: stop smoking improve relationship better food choices change job

HPI

Allergies or intolerance to drugs or other substances:	**Reaction:**

Current medications:	**Dose / Times per day you take them:**

Please check all conditions that apply:

GENERAL
- ☐ Serious Infections (E.g. pneumonia) _____
- ☐ Diabetes Mellitus/Insulin Resistance
- ☐ Rheumatic Fever
- ☐ HIV Infection
- ☐ Cancer _____

CVS
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Blood Clots in Veins
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Legs

HEENT
- ☐ Glaucoma
- ☐ Allergies "hay fever"
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infection

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Blood Clots in Lungs
- ☐ Sleep Apnea

MUSCULOSKELATAL/ EXTREMITIES
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Neck Pain (herniated disc)
- ☐ Back Pain (herniated disc)

LYMPHATIC/HEMATOLOGIC
- ☐ Thyroid
- ☐ Over active Thyroid
- ☐ Under Active Thyroid
- ☐ Transfusion
- ☐ Anemia

GI/GU
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohns Disease
- ☐ Bleeding from Intestines
- ☐ Diverticulitis
- ☐ Colon Polyps
- ☐ Irritable Bowel Disease
- ☐ Hepatitis
- ☐ Cirrhosis of the Liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Disease
- ☐ Endometriosis
- ☐ Sex Transmitted Infection

SKIN/BREAST
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC
- ☐ Chronic Vertigo (Meniere's)
- ☐ Peripheral Nerve Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Anxiety

OTHER _____

Please indicate when you had the following preventative tests and services:

- ____ Cardiac Angiogram
- ____ Stress Test
- ____ Echocardiogram
- ____ Chest X-ray
- ____ EKG
- ____ Flu Vaccine
- ____ Pneumonia Vaccine
- ____ Tetanus Vaccine
- ____ Hepatitis Vaccine
- ____ Bone Density
- ____ Prostate Cancer Blood Test
- ____ Rectal Exam
- ____ Colon Cancer Stool Test
- ____ Flexible Sigmoidoscopy
- ____ Barium Enema
- ____ Mammogram/Breast Exam
- ____ Pap Smear
- ____ Date of last Physical Exam
- ____ Other _____

SURGICAL HISTORY

Please check all surgeries that apply and the date they were performed:

YEAR:	YEAR:	YEAR:	YEAR:
_____ Angioplasty	_____ Trauma Related Surgery	_____ Stomach Surgery	_____ Tubal Ligation
_____ Carotid Artery Surgery	_____ Back or Neck Surgery	_____ Inguinal Hernia	_____ C-Section
_____ Other Vascular Surgery	_____ Hip Surgery	_____ Colonoscopy	_____ Hysterectomy
_____ Coronary Bypass Surgery	_____ Knee Surgery	_____ Gallbladder	_____ Ovary Removal
_____ Chest/Lung Surgery	_____ Carpal Tunnel Surgery	_____ Appendectomy	_____ Breast Surgery
_____ Tonsillectomy	_____ Sinus Surgery	_____ Prostate Surgery	_____ Thyroid Surgery
_____ Neurosurgery	_____ Ear Surgery	_____ Bladder Surgery	_____ Other_____

FAMILY MEDICAL HISTORY

Please check any major illness in your family and list who it pertains to (Mother, Father, Paternal Grandfather, etc.):

❑ Heart Disease	_____	age _____	_____	age _____
❑ High Blood Pressure	_____	age _____	_____	age _____
❑ Osteoporosis	_____	age _____	_____	age _____
❑ Diabetes Mellitus	_____	age _____	_____	age _____
❑ Kidney Disease	_____	age _____	_____	age _____
❑ Liver Disease	_____	age _____	_____	age _____
❑ Neurological Disease	_____	age _____	_____	age _____
❑ Anemia	_____	age _____	_____	age _____
❑ Cancer	_____	age _____	_____	age _____
❑ Other	_____	age _____	_____	age _____

SOCIAL / MENTAL HISTORY

Plese circle or write the information that applies to you:

Religion: ☐ none ☐ _____

Living Status: ☐ alone ☐ with spouse ☐ with parents ☐ other

Sexually Active: ☐ yes ☐ no

Exercise: ☐ no ☐ yes _____

Diet: ☐ none ☐ low fat ☐ low carb ☐ vegetarian ☐ other

Alternative Medicine: ☐ chiropractic ☐ acupuncture ☐ herbal

Do you feel anxiety more days than not? ☐ yes ☐ no

Do you feel anxiety contributes to your physical health? ☐ yes ☐ no

Do you want to try to learn how to be less anxious? ☐ yes ☐ no

Do you consider yourself a glass "half-full" or glass "half-empty" person?

☐ glass "half-full" ☐ glass "half-empty"

Do you feel depressed more days than not? ☐ yes ☐ no

Tobacco: never past active

☐ cigararette ☐ cigar ☐ pipe
☐ snuff ☐ dip ☐ chewing

start_____ stop _____

pack per day _____

Alcohol: never past active

☐ Liquor ☐ Wine ☐ Beer

___ drink(s) per day / wk / mo

☐ AA ☐ alcohol rehab

Illicit Drugs: never past active

☐ cocain ☐ marijuana ☐ heroin
☐ amphetamine ☐ barbituate
☐ LSD ☐ PCP

☐ IV drug abuse ☐ drug rehab

Caffeine: never past active

☐ coffee ☐ tea ☐ soda

_____ can / cup per day