Initial History (Adults)

Patient Name _____ Sex ☐ M ☐ F DoB ____/____/____ Chart # _____

Form completed by _____ Relation (if other than patient) _____ Date ____/____/____

Family

Are you: ☐ single ☐ married ☐ partner ☐ separated/divorced ☐ widowed _____

List members of the immediate family

Name	Age	Relation	Health Problems

Work History

Are you currently employed outside the home? ☐ Yes ☐ No If not, are you: ☐ retired ☐ disabled ☐ other _____

Present type of work _____

In your work, are you exposed to: ☐ harmful toxins ☐ heavy lifting ☐ extremes in temperatures ☐ undue stress ☐ other potential hazards

Current Medical History

Are immunizations up to date? ☐ Yes ☐ No

Are you having any medical problems? ☐ Yes ☐ No

Current Medications:

Drug Allergies? ☐ Yes ☐ No

Past Medical History

Have you ever had a serious medical problem? ☐ Yes ☐ No _____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No _____

Have you ever had a serious injury? ☐ Yes ☐ No _____

_____

_____

History Update

(date/initial) Changes in history noted in chart on day of visit.

_____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____

_____ ____ _____ ____ _____ ____ _____ ____ _____ ____ _____ ____

Patient Name _____ Date ____/____/____ Chart # _____

Review of Systems

Are you concerned about (circle concerns):

		Yes	No	*Explain*
1.	eating habits, weight loss, ↓ energy, sleep problems	☐	☐	_____
2.	eye pain, redness, ↑ tearing, drainage, blurred or ↓ vision	☐	☐	_____
3.	ear, nose, mouth, throat, sinus problems, ↓ hearing	☐	☐	_____
4.	heart problems, chest pain, ↑ blood pressure, leg swelling	☐	☐	_____
5.	lung problems: difficult breathing, wheezing, infections	☐	☐	_____
6.	abdominal pain, vomiting, indigestion, excessive gas	☐	☐	_____
7.	diarrhea, constipation, blood in stools, hemorrhoids	☐	☐	_____
8.	kidney or bladder problems, infections, blood in urine	☐	☐	_____
9.	joint pain, stiffness, swelling, muscle pain, weakness	☐	☐	_____
10.	skin: rashes, itching, dryness; hair or nail problems	☐	☐	_____
11.	headaches, dizziness, numbness, weakness, seizures	☐	☐	_____
12.	stress, anxiety, sadness, depression, suicidal thoughts	☐	☐	_____
13.	excessive thirst or hunger, ↑ urination, weight loss	☐	☐	_____
14.	anemia, bruising, bleeding problems, had blood transfusions	☐	☐	_____
15.	allergies: food, hay fever, asthma, ↑ infections	☐	☐	_____
16.	(women) breasts, menstruation, irregular bleeding patterns, hot flashes, pain or bleeding with intercourse, other sexual concerns	☐	☐	_____
	Do you now take or have you taken hormone therapy?	☐	☐	_____
	Approximate date of last: Menstrual Period _____			_____
	Pap Test _____ Mammogram _____			_____
17.	(men) lesions or swelling on penis, scrotum or testicles; difficulty urinating, enlarged prostate, difficulty getting or sustaining an erection, other sexual concerns	☐	☐	_____
	Have you had a PSA (prostate) test? When _____	☐	☐	_____
18.	Do you exercise for 30 minutes? ☐ Daily ☐ Weekly ☐ Seldom	☐	☐	_____
19.	Do you take calcium, multivitamins, or folic acid?	☐	☐	_____
20.	Do you smoke, drink alcohol or use recreational drugs?	☐	☐	_____

Family History

If patient or a family member has or has had any of the following problems, check the appropriate box and list the family member:
P-Patient M-Mother F-Father C-Child S-Sibling GM-Grandmother GF-Grandfather A-Aunt U-Uncle

1.	☐ _____ Allergies	11.	☐ _____ High cholesterol	21.	☐ _____ Cancer
2.	☐ _____ Drug allergies	12.	☐ _____ High blood pressure before 50 yrs	22.	☐ _____ Neurological/Seizures
3.	☐ _____ Eczema/Skin problems	13.	☐ _____ Heart attack/stroke before 50 yrs	23.	☐ _____ Arthritis
4.	☐ _____ Asthma/Lung problems	14.	☐ _____ Other heart problems	24.	☐ _____ Phlebitis
5.	☐ _____ Respiratory infections	15.	☐ _____ Anemia/Blood disorders	25.	☐ _____ Hereditary problems
6.	☐ _____ Eye or visual problems	16.	☐ _____ Diabetes before 50 yrs	26.	☐ _____ Emotional/Behavioral
7.	☐ _____ Ear problems/Deafness	17.	☐ _____ Thyroid or other endocrine problem	27.	☐ _____ Mental illness
8.	☐ _____ Tuberculosis	18.	☐ _____ Obesity	28.	☐ _____ Mental retardation
9.	☐ _____ Liver Disease	19.	☐ _____ Bladder/Kidney problems	29.	☐ _____ Drug/Alcohol abuse
10.	☐ _____ Immunity problems/HIV	20.	☐ _____ Stomach/GI problems	30.	☐ _____ Other

Provider Comments

History Reviewed by _____