

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	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. eye pain, redness, ↑ tearing, drainage, blurred or ↓ vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. ear, nose, mouth, throat, sinus problems, ↓ hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. heart problems, chest pain, ↑ blood pressure, leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. lung problems: difficult breathing, wheezing, infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. abdominal pain, vomiting, indigestion, excessive gas	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. diarrhea, constipation, blood in stools, hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. kidney or bladder problems, infections, blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. joint pain, stiffness, swelling, muscle pain, weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. skin: rashes, itching, dryness; hair or nail problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. headaches, dizziness, numbness, weakness, seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. stress, anxiety, sadness, depression, suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. excessive thirst or hunger, ↑ urination, weight loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. anemia, bruising, bleeding problems, had blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. allergies: food, hay fever, asthma, ↑ infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. (women) breasts, menstruation, irregular bleeding patterns, hot flashes, pain or bleeding with intercourse, other sexual concerns	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you now take or have you taken hormone therapy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had a PSA (prostate) test? When _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Do you exercise for 30 minutes? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Seldom	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Do you take calcium, multivitamins, or folic acid?	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Do you smoke, drink alcohol or use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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:*

	<i>P-Patient</i>	<i>M-Mother</i>	<i>F-Father</i>	<i>C-Child</i>	<i>S-Sibling</i>	<i>GM-Grandmother</i>	<i>GF-Grandfather</i>	<i>A-Aunt</i>	<i>U-Uncle</i>
1. <input type="checkbox"/> Allergies									
2. <input type="checkbox"/> Drug allergies									
3. <input type="checkbox"/> Eczema/Skin problems									
4. <input type="checkbox"/> Asthma/Lung problems									
5. <input type="checkbox"/> Respiratory infections									
6. <input type="checkbox"/> Eye or visual problems									
7. <input type="checkbox"/> Ear problems/Deafness									
8. <input type="checkbox"/> Tuberculosis									
9. <input type="checkbox"/> Liver Disease									
10. <input type="checkbox"/> Immunity problems/HIV									
11. <input type="checkbox"/> High cholesterol									
12. <input type="checkbox"/> High blood pressure before 50 yrs									
13. <input type="checkbox"/> Heart attack/stroke before 50 yrs									
14. <input type="checkbox"/> Other heart problems									
15. <input type="checkbox"/> Anemia/Blood disorders									
16. <input type="checkbox"/> Diabetes before 50 yrs									
17. <input type="checkbox"/> Thyroid or other endocrine problem									
18. <input type="checkbox"/> Obesity									
19. <input type="checkbox"/> Bladder/Kidney problems									
20. <input type="checkbox"/> Stomach/GI problems									
21. <input type="checkbox"/> Cancer									
22. <input type="checkbox"/> Neurological/Seizures									
23. <input type="checkbox"/> Arthritis									
24. <input type="checkbox"/> Phlebitis									
25. <input type="checkbox"/> Hereditary problems									
26. <input type="checkbox"/> Emotional/Behavioral									
27. <input type="checkbox"/> Mental illness									
28. <input type="checkbox"/> Mental retardation									
29. <input type="checkbox"/> Drug/Alcohol abuse									
30. <input type="checkbox"/> Other									

Provider Comments

History Reviewed by _____