ADULT PATIENT INFORMATION

PATIENT INFORMATION

Name: _____ Date of birth: _____

Phone Number: _____ Today's Date: _____

Allergies: _____

Is patient adopted? ❑ Yes ❑ No _____

Interpreter needed? ❑ Yes ❑ No _____

Medications

Please list all the medications you are taking, including any vitamins, herbal medicines, and "over-the-counter" medications.

Name of medication	Dose	Frequency

Medical History

If your answer is "Yes" to a question, please explain on the line following the question.

None?	☐	Yes	☐	No
Thyroid Problems?	☐	Yes	☐	No
Seizures?	☐	Yes	☐	No
Stroke?	☐	Yes	☐	No
Asthma?	☐	Yes	☐	No
C.O.P.D./Emphysema.....	☐	Yes	☐	No
Sleep Apnea?	☐	Yes	☐	No
Coronary Artery Disease?	☐	Yes	☐	No
Congestive Heart Failure?	☐	Yes	☐	No
Chest Pain?	☐	Yes	☐	No
High Blood Pressure?	☐	Yes	☐	No
Elevated Cholesterol?	☐	Yes	☐	No
Heart Attack?	☐	Yes	☐	No
Implantable Devices?	☐	Yes	☐	No
Cardiac Arrhythmia?	☐	Yes	☐	No
Rheumatic Fever?	☐	Yes	☐	No
Diabetes?	☐	Yes	☐	No
Liver Problems?	☐	Yes	☐	No
Stomach Problems?	☐	Yes	☐	No
Irritable Bowel Syndrome?	☐	Yes	☐	No
Reflux (G.E.R.D.)?	☐	Yes	☐	No
Kidney Problems?	☐	Yes	☐	No
Incontinence of Urine?	☐	Yes	☐	No

Medical History *(continued)*

Genitourinary Problems?	☐	Yes	☐	No
Osteoporosis?	☐	Yes	☐	No
Back or Neck Problems?	☐	Yes	☐	No
Arthritis?	☐	Yes	☐	No
Skin Problems?	☐	Yes	☐	No
Anemia?	☐	Yes	☐	No
Blood Disorder?	☐	Yes	☐	No
Hepatitis?	☐	Yes	☐	No
HIV or AIDS?	☐	Yes	☐	No
STDs?	☐	Yes	☐	No
Depression?	☐	Yes	☐	No
Anxiety?	☐	Yes	☐	No
Eating Disorder?	☐	Yes	☐	No
Menstrual Problems?	☐	Yes	☐	No
Abnormal Pap Smear?	☐	Yes	☐	No
Cancer?	☐	Yes	☐	No
Other Medical Problems?	☐	Yes	☐	No
Hospitalizations?	☐	Yes	☐	No
Are immunizations on schedule?	☐	Yes	☐	No
Previous reaction to immunizations?.....	☐	Yes	☐	No

Surgical History

If your answer is "Yes" to a question, please explain on the line following the question.

None?	☐	Yes	☐	No
Appendectomy?	☐	Yes	☐	No
Breast Biopsy?	☐	Yes	☐	No
Cholecystectomy?	☐	Yes	☐	No
Coronary Artery Bypass?	☐	Yes	☐	No
Hernia?	☐	Yes	☐	No
Hip Replacement?	☐	Yes	☐	No
Hysterectomy?	☐	Yes	☐	No
Knee Replacement?	☐	Yes	☐	No
Other surgical procedures?	☐	Yes	☐	No

Social History

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other:

Occupation: _____

Highest level of education: ❍ College ❍ High school ❍ G.E.D. ❍ Other:

Number of living children: _____

Do you have special religious or cultural needs? ❑ Yes ❑ No _____

(continued ….)

Family History

Please indicate which of your relatives has had any of the following conditions.

	Parent		Parent		Maternal		Maternal		Paternal		Paternal		Siblings	
	Mother	Age of Onset	Father	Age of Onset	Grand-mother	Age of Onset	Grand-father	Age of Onset	Grand-mother	Age of Onset	Grand-father	Age of Onset	Sister	Brother
Unknown ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Aneurysms ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Bleeding tendencies ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Breast cancer ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Colo-Rectal Cancer ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Ovarian cancer ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Pancreatic cancer ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Other cancers ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Diabetes ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Alcohol dependence ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Drug abuse ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Heart problems ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Hypertension ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Stroke ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Mental illness ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐
Other health problems ❑ Y ❑ N	☐		☐		☐		☐		☐		☐		☐	☐

Is your father deceased? ..... ☐ Yes ☐ No _____

Is your mother deceased? ..... ☐ Yes ☐ No _____

HEALTH RISK PROFILE

If your answer is "Yes" to a question, please explain on the line following the question.

Latex Allergy Risk

Allergic to latex?	☐	Yes	☐	No
Reaction to a medical procedure?	☐	Yes	☐	No
Reaction to a dental procedure?	☐	Yes	☐	No
Allergic to shellfish ?	☐	Yes	☐	No
Allergic to nuts?	☐	Yes	☐	No

_____

Smoking Status

Current every day smoker? .....❑ Yes ❑ No _____

Current some day smoker? .....❑ Yes ❑ No _____

Former smoker? .....❑ Yes ❑ No _____

Never smoker? .....❑ Yes ❑ No _____

Smoker current status unknown? .....❑ Yes ❑ No _____

Unknown if ever smoke? .....❑ Yes ❑ No _____

Exposure to secondhand smoke? ❑ No ❑ Yes (If "yes," who and where?): _____

Other tobacco use? .....❑ Yes ❑ No _____

Alcohol Use?.....❑ Yes ❑ No _____

Recreational Drug Use?.....❑ Yes ❑ No _____

Caffeine Use?.....❑ Yes ❑ No _____

(continued…)

HEALTH RISK PREVENTION

Exercise regularly? ..... ❑ Yes ❑ No _____
Maintain a healthy weight? ..... ❑ Yes ❑ No _____
Helmet use? ..... ❑ Yes ❑ No _____
Seatbelt use? ..... ❑ Yes ❑ No _____
Smoke detectors in your home? ..... ❑ Yes ❑ No _____
Carbon monoxide detectors in your home?. ❑ Yes ❑ No _____

HEALTH RISK HAZARD EXPOSURE

Lead exposure? ..... ❑ Yes ❑ No _____
Exposure to other chemicals? ..... ❑ Yes ❑ No _____
Sexually active? ..... ❑ Yes ❑ No _____

TYPE OF CONTRACEPTION

Birth control pill? ..... ❑ Yes ❑ No _____
Birth control patch? ..... ❑ Yes ❑ No _____
Birth control ring? ..... ❑ Yes ❑ No _____
Condoms? ..... ❑ Yes ❑ No _____
Diaphragm / cap / shield? ..... ❑ Yes ❑ No _____
Depo Provera? ..... ❑ Yes ❑ No _____
Implant? ..... ❑ Yes ❑ No _____
I.U.D.? ..... ❑ Yes ❑ No _____
None? ..... ❑ Yes ❑ No _____
Sponge / spermicide? ..... ❑ Yes ❑ No _____
Tubal sterilization? ..... ❑ Yes ❑ No _____
Vasectomy? ..... ❑ Yes ❑ No _____
Other? ..... ❑ Yes ❑ No _____
Do you feel safe at home? ..... ❑ Yes ❑ No _____
Do you want to discuss abuse? ..... ❑ Yes ❑ No _____
Is someone threatening you? ..... ❑ Yes ❑ No _____

Symptoms — *Please check any of the following symptoms that you have now or have had recently.*

◯ Fever	◯ Unexplained weight loss	◯ Chills
◯ Changes in vision	◯ Difficulty swallowing	◯ Problems with hearing
◯ Chest pain	◯ Racing heart	◯ Palpitations
◯ Cough	◯ Wheezing	◯ Shortness of breath
◯ Stomach pains	◯ Blood in stool	◯ Constipation
◯ Blood in urine	◯ Burning during urination	◯ Difficulty starting/stopping stream
◯ Joint pain	◯ Black stools	◯ Foot swelling
◯ Depression	◯ Anxiety	◯ Panic attacks
◯ Excessive thirst	◯ Frequent urination	◯ Swelling in the neck
◯ Swollen glands	◯ Easy bleeding	◯ Poor healing
◯ Frequent headaches	◯ Loss of consciousness	◯ Numbness in arms/legs
◯ Worrisome or changing skin lesions	◯ Hair loss	◯ Skin rashes