



ADULT PATIENT INFORMATION



PATIENT INFORMATION

Name: _____ Date of birth: _____

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.? 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 _____

(continued)

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 _____
- M.R.S.A. / V.R.E.? Yes No _____
- Tuberculosis? Yes No _____
- C-difficile? 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 _____

(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	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysms.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendencies	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colo-Rectal Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic cancer...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cancers	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol dependence	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug abuse	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other health problems	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is your father deceased? Yes No _____

Is your mother deceased? 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 _____

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 bananas? Yes No _____

Allergic to kiwis? Yes No _____

Allergic to avocados? Yes No _____

Allergic to chestnuts? Yes No _____

Tobacco use? Yes No _____

Prior tobacco use? Yes No _____

Exposure to secondhand smoke? Yes No _____

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 circle 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