Legacy Family Medicine, P.C.

ADULT PATIENT HISTORY

Patient Name: _____ Date: _____ Sex: ☐ M ☐ F Birthdate _____

MEDICATIONS (including over-the-counter medications, herbal supplements)

_____

_____

_____

_____

MEDICAL PROBLEMS

_____

_____

_____

PREVIOUS HOSPITALIZATIONS/SURGERIES
(date, reason, hospital/physician)

_____

_____

_____

SAFETY:

1. Do you buckle your safety belt when driving or riding? ☐ Yes ☐ No
2. Do you wear a helmet when riding a bicycle, motorcycle, etc. ☐ Yes ☐ No
3. Do you have current & operational smoke detectors and carbon monoxide detectors? ☐ Yes ☐ No
4. Do you have an updated First-Aid Kit in your home? ☐ Yes ☐ No
5. a) Do you feel safe at home? ☐ Yes ☐ No
   b) Has anyone ever
   - hit you? ☐ Yes ☐ No
   - insulted you or put you down? ☐ Yes ☐ No
   - threatened you? ☐ Yes ☐ No
   - forced sex upon you? ☐ Yes ☐ No

   c) If you answered "yes" to any part of number 5b, would you like help dealing with this situation? ☐ Yes ☐ No
6. Do you take safety precautions with firearms in the home? ☐ Yes ☐ No

ALLERGIES:

_____

_____

_____

_____

Latex/tape allergy ☐ Y ☐ N

FAMILY HISTORY
If any of these relatives have had any of these conditions, please check the appropriate box

	Mother	Father	Sister / Brother	Grandparents
Diabetes				
Cancer				
Heart Disease				
Stroke				
High blood pressure				
Seizures				
Glaucoma				
Thyroid Disease				
Kidney Disease				
Mental Illness				

Please indicate the date of your:

Last Tetanus Shot	
Last Pneumonia shot	
Last MMR shot	
Last Hepatitis B shot	
Last eye exam	
Last dental exam	
Last TB test	
Last PSA test (men)	
Last PAP (women)	
Last Mammogram	
Last Bone Density	

SOCIAL HISTORY

Tobacco use *(smoke or chew)*: ☐ yes ☐ no If yes, what?_____ How much?_____ per day x _____ years ☐

Alcohol use: ☐ yes ☐ no If yes, what?_____ How much?_____ per day _____ x per week ☐

Recreational Drugs: ☐ yes ☐ no If yes, what?_____ How much?_____ per day _____ x per week ☐

Caffeine: ☐ yes ☐ no If yes, source _____ amount _____ per day ☐

Exercise: ☐ yes ☐ no If yes, specify type _____ How often? _____ ☐

Occupation:_____ Contact with chemicals or blood / body fluids at work: ☐ yes ☐ no

Use/activity in the past

ADVANCE DIRECTIVES: **Do you have an Advance Directive, i.e., written instructions for your family and health care provider in the event that you cannot make a decision yourself about your care?** ☐ Yes ☐ No

Would you like information on Advance Directives? ☐ Yes ☐ No Info given ☐ (staff use)

(SEE REVERSE)

MEDICAL HISTORY

(Check any past/current problems)

Patient Name: _____ Birthdate _____

GENERAL:
❑ fever ❑ chills ❑ sweats ❑ fatigue
❑ sleeplessness ❑ headaches ❑ dizziness
❑ weakness ❑ **loss of appetite**
❑ **weight loss/gain** ❑ **eating problems**

EYES:
❑ drainage ❑ redness ❑ itching
❑ blurring ❑ double vision

EARS, NOSE, THROAT, MOUTH:
❑ pain/pressure (areas) _____
❑ congestion/draining (areas) _____
❑ sneezing ❑ decreased hearing
❑ bad breath ❑ frequent nose bleeds
❑ problem with teeth/gums ❑ hoarseness

RESPIRATORY:
❑ shortness of breath ❑ cough
❑ wheezing ❑ blood sputum
❑ congestion/heaviness in chest
❑ asthma ❑ tuberculosis

CARDIOVASCULAR:
❑ high blood pressure
❑ chest pain/pressure ❑ irregular/rapid beat
❑ jaw/shoulder/arm pain
❑ excessive sweating ❑ poor coloring
❑ swelling/fluid retention ❑ rheumatic fever
❑ varicose veins/phlebitis

GASTROINTESTINAL:
❑ **stomach problems**
❑ **indigestion/heartburn** ❑ **nausea** ❑ **vomiting**
❑ gas ❑ **diarrhea** ❑ **constipation**
❑ blood in stools ❑ blood in vomitus
❑ hemorrhoids ❑ pain
❑ rectal bleeding ❑ **change in bowel habits**
❑ gallbladder disease ❑ hepatitis

GENITOURINARY:
❑ kidney/bladder problems
❑ burning/painful urination ❑ frequency
❑ night urination ❑ blood in urine
❑ genital sores ❑ vaginal/penile discharge
❑ pelvic pain ❑ itching ❑ bleeding
❑ prostate disease

MUSCULOSKELETAL:
❑ body ache ❑ stiffness (area) _____
❑ swelling ❑ joint pain (area) _____
❑ warmth ❑ arthritis/gout

SKIN and/or BREAST:
❑ wounds (area) _____
❑ sores (area) _____
❑ dryness ❑ itching ❑ rashes
❑ discoloration ❑ tightening ❑ bruise easily

NEUROLOGICAL:
❑ tingling (area) _____
❑ numbness ❑ paralysis
❑ convulsions/seizures

PSYCHIATRIC:
❑ stress ❑ depression ❑ anxiety
❑ agitation ❑ memory loss

ENDOCRINE:
❑ thyroid trouble ❑ heat or cold intolerance
❑ excessive sweating ❑ thirst ❑ hunger
❑ **diabetes**

HEMATOLOGIC/LYMPHATIC:
❑ swollen glands ❑ tenderness of glands
❑ **anemia**

ALLERGIC/IMMUNOLOGIC:
❑ respiratory distress ❑ hives ❑ itching
❑ difficulty swallowing ❑ swelling
❑ hay fever

SEXUAL:
Sexual orientation? ❑ heterosexual
❑ bisexual
❑ homosexual
❑ other
Number of partners? _____ total
_____ last 10 years
_____ current
Do you practice safe sex? ❑ always
❑ usually
❑ sometimes
❑ rarely
❑ sexual problems ❑ sexually transmitted disease
❑ HIV exposure

Information given by: _____ Relationship to patient: _____ Date: _____

OFFICE USE ONLY

Bold print in medical history may indicate dietician/nutritional assessment.

Special Learning Needs: ❑ No ❑ Yes, specify: _____

Language Preference: ❑ English ❑ Other specify: _____

Reviewed by: _____ Date: _____ / _____ / _____