



8132 Cordova Road, Suite 102
Cordova, TN 38016

Name _____

Date _____

Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific detail please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

Where were you getting your care before? _____

In the past 2 weeks, have you been bothered by:

Little interest or pleasure in doing things?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Feeling down, depressed or hopeless?	<input type="checkbox"/> No <input type="checkbox"/> Yes

REVIEW OF SYMPTOMS: Please mark the box and/or circle any persistent symptoms you have had in the past few months. Re through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

- | | | |
|---|--|---|
| General | Respiratory | Hematologic/Lymphatic |
| <input type="checkbox"/> Unexplained weight loss / gain | <input type="checkbox"/> Cough / wheeze | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Unexplained fatigue / weakness | <input type="checkbox"/> Loud snoring / altered breathing during sleep | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Fall asleep during day when sitting | <input type="checkbox"/> Short of breath with exertion | <input type="checkbox"/> No problems |
| <input type="checkbox"/> Fever, chills | <input type="checkbox"/> No problems | Neurological |
| <input type="checkbox"/> No problems | Gastrointestinal | <input type="checkbox"/> Headache |
| Skin | <input type="checkbox"/> Heartburn / reflux / indigestion | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> New or change in mole | <input type="checkbox"/> Blood or change in bowel movement | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Rash / itching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> No problems | <input type="checkbox"/> No problems | <input type="checkbox"/> Numbness / tingling |
| Breast | Genitourinary | <input type="checkbox"/> Unsteady gait |
| <input type="checkbox"/> Breast lump / pain / nipple discharge | <input type="checkbox"/> Leaking urine | <input type="checkbox"/> Frequent falls |
| <input type="checkbox"/> No problems | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> No problems |
| Ears/Nose/Throat | <input type="checkbox"/> Nighttime urination or increased frequency | Allergic/Immune |
| <input type="checkbox"/> Nosebleeds, trouble swallowing | <input type="checkbox"/> Discharge: penis or vagina | <input type="checkbox"/> Hay fever / allergies |
| <input type="checkbox"/> Frequent sore throat, hoarseness | <input type="checkbox"/> Concern with sexual function | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Hearing loss / ringing in ears | <input type="checkbox"/> No problems | <input type="checkbox"/> No problems |
| <input type="checkbox"/> No problems | Musculoskeletal | Psychiatric |
| Eyes | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Anxiety / stress / irritability |
| <input type="checkbox"/> Change in vision / eye pain / redness | <input type="checkbox"/> Back pain | <input type="checkbox"/> Sleep problem |
| <input type="checkbox"/> No problems | <input type="checkbox"/> Muscle / joint pain | <input type="checkbox"/> Lack of concentration |
| Cardiovascular | <input type="checkbox"/> No problems | <input type="checkbox"/> No problems |
| <input type="checkbox"/> Chest pain / discomfort | Endocrine | Women only |
| <input type="checkbox"/> Palpitations (fast or irregular heartbeat) | <input type="checkbox"/> Heat or cold sensitivity | <input type="checkbox"/> Pre-menstrual symptoms (bloating cramps, irritability) |
| <input type="checkbox"/> No problems | <input type="checkbox"/> No problems | <input type="checkbox"/> Problem with menstrual periods |
| | | <input type="checkbox"/> Hot flashes / night sweats |
| | | <input type="checkbox"/> No problems |

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information.

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot or illness _____ Pneumovax (pneumonia) _____
Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.
 TAKE NO MEDICATIONS,

Medication	Dose (e.g. mg/pill)	How many times per day?

Allergies or intolerance to medications (include type of reaction): _____ **NONE**

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date _____	Abnormal?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sigmoidoscopy or Colonoscopy (circle one)	Date _____	Polyp?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<i>Women only:</i>				
Mammogram	Date _____	Abnormal?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Pap Smear	Date _____	Abnormal?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bone Density Test	Date _____	Abnormal?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions? **NONE**

Condition	Code	Current	Past	Comments
Alcohol / Drug abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder / Kidney Problems				
Blood Clot (leg)	453.40			
Blood Clot (lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Fractures (broken bones)				Where?
Gallbladder Disease	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			

PERSONAL MEDICAL HISTORY Continued:				
Condition	Code	Current	Past	Comments
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.90			
Hepatitis - Type A	070.1			
Hepatitis - Type B	070.30			
Hepatitis - Type C	070.51			
Hepatitis - Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive) / Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (list)				
Other (list)				

SURGICAL HISTORY - Please check off any procedure or surgeries. List any abnormal finding or complications. NONE

Surgical Procedure	Code	Yes	Year	Comments
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				
Breast Surgery				Circle: Right Left Both
Colonoscopy				Circle: Right Left Both
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				
Heart Surgery (other than coronary bypass)				Circle: Laparoscopic
Hip Surgery				
Hysterectomy (total, including ovaries)				Circle: Right Left Both
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
				Circle: Laparoscopic Vaginal Abdominal

SURGICAL HISTORY Continued:				
Surgical Procedure	Code	Yes	Year	Comments
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				Circle: Right Left Both
Ovary Removal				
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to page 5 (Other Health Issues)

FAMILY HISTORY – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

OTHER HEALTH ISSUES:

Tobacco Use

Smoke cigarettes: Never No Yes
(If you never smoked please go to alcohol use question now)

Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____

Other tobacco: Pipe Cigar Snuff Chew

Alcohol Use

Do you drink alcohol? No Yes

of drinks/week: _____ Beer Wine Liquor

Drug Use

Do you use marijuana or recreational drugs? No Yes

Have you ever used needles to inject drugs? No Yes

Sexual Activity

Sexually involved currently: No Yes

Sexual partner(s) is/are/have been: male female

Birth control method (circle below all that apply): None needed

Condom, pill, diaphragm, vasectomy, other _____

Exercise: Do you exercise regularly? Yes No

What kind of exercise? _____

How long (minutes)? _____ How often? _____

Diet: How would you rate your diet? Good Fair Poor

Would you like advice on your diet? No Yes

Safety: Do you use a bike helmet? No bike Yes No

Do you use seatbelts consistently? Yes No

Does your home have a working smoke detector? Yes No

If you have guns in your home, are they locked up?
 Not applicable Yes No

Is violence at home a concern for you? No Yes

Have you completed an Advance Directive for Health Care (ADHC),
Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?
(Circle above all that apply) Yes No

SOCIAL HISTORY:

Occupation (or prior occupation): _____ retired/unemployed/leave of absence/disabled (circle one)

Employer: _____ Years of education or highest degree: _____

Marital status (circle one): single, partner, married, divorced, widowed, other: _____

Spouse/partner's name: _____ Number of children: _____ Ages if under 18 years: _____

Number of grandchildren: _____ Number of great grandchildren: _____

Who lives at home with you? _____

Leisure activities, group involvement, religion, volunteer work, recent travel: _____

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date (month/day if known) of last menstrual period if you are still menstruating: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

Thank-you for taking the time to fill this out.

