

DATE _____

ADULT PATIENT DATA BASE

NAME _____
SS# _____

DOB _____ SEX F M
PHONE# _____

PAST MEDICAL HISTORY

List Any Current Medical Problems: _____

List Any Surgeries: _____

List Any Other Hospital Stays: _____

List Any Physicians/Practitioners You Currently See: _____

List Any Allergies to Medication or X-Ray Dyes: _____

List Any Medications (include over the counter): _____
(Please use the back if necessary)

Any Blood Transfusions? Yes No when? _____

Any Problems with Anesthesia? Yes No what? _____

For Women Only:

Age of Onset of Period: _____ Number of Pregnancies: _____
Age of Cessation of Periods: _____ Length of Periods: _____
How Many Days Apart are Periods? _____ Are Periods Regular? Yes No

FAMILY HISTORY:

Please list any health problems and causes of death if applicable.

	AGE	
Father		
Mother		
Brother(s)		
Sister(s)		

	AGE	
Mother's father		
Mother's mother		
Father's father		
Father's mother		

NAME: _____

SS# _____

DOB: _____

Any other illnesses
in the Family:

TB

Stroke

Arthritis

Diabetes

Epilepsy

Glaucoma

Asthma

Heart Disease

Bleeding Disorders

High Blood Pressure

Depression/Psychiatric Illness

Cancer, if so what type? _____

SOCIAL HISTORY

Marital Status: Married Single Divorced Widowed

Occupation: _____

How many Children: _____

Ages: _____

List everyone in Household including pets: _____

Do you smoke or chew tobacco? Yes No If yes, how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you consume caffeine? Yes No If yes, how much per day? _____

Do you use any recreational drugs? Yes No What do you use? _____

Do you use sunscreen regularly? Yes No

Do you have guns in your house? Yes No

Do you wear seatbelts? Yes No

Do you wear a bike helmet? Yes No

Do you have workable smoke detectors in your house? Yes No

Do you do some form of regular exercise every day? Yes No At least 3 days per week? _____

Are you sexually active? Yes No

Do you participate in any activities that put you at risk of getting AIDS? Yes No

If sexually active, what form of contraception do you use? _____

Are you happy? Yes No

OTHER

Do you have difficulty doing usual activities? Yes No

Do you have an advanced directive (living will)? Yes No

Do you do breast self exams? Yes No

Do you check your testicles for lumps? Yes No

Do you take a calcium supplement? Yes No

Do you take an aspirin everyday? Yes No

Have you been exposed to any hazardous materials? Yes No

Have you ever been in an abusive relationship? Yes No

Are you afraid of your partner? Yes No

Have you been in any automobile accidents? Yes No

Work related accidents? Yes No

HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank.

Pneumonia vaccine (shot) _____

Hepatitis vaccine (shot) _____

Tetanus vaccine (shot) _____

Tuberculosis Test _____

Flu vaccine (shot) _____

Women:

Pap _____

Mammogram _____

Breast Exam _____

Rectal Exam _____

NAME: _____

SS# _____

DOB: _____

HEALTH MAINTENANCE - CON'T

Mumps, Measles, Rubella _____ (Shot #2)

Chest X-Ray _____

EKG _____

Cholesterol _____

Stool check for blood _____

Dental Exam _____

Eye Exam _____

Men:

Prostate _____

PSA _____ (Blood test for prostate cancer)

Rectal Exam _____

REVIEW OF SYSTEMS

Please circle if you have had problems with or are presently complaining of any of the following:

- | | | |
|------------------------|----------------------------------|--------------------------|
| 1. High blood pressure | 17. Hay Fever | 33. Head or neck |
| 2. Diabetes | 18. Abdominal discomfort | 34. Headache |
| 3. Cancer | 19. Indigestion | 35. Kidney diseases |
| 4. Heart disease | 20. Nausea | 36. Kidney stones |
| 5. Chest pain | 21. Vomiting | 37. Difficulty urinating |
| 6. Shortness of breath | 22. Constipation | 38. Arthritis |
| 7. Swollen ankles | 23. Diarrhea | 39. Low back problems |
| 8. Palpitations | 24. Blood in stool | 40. Skin diseases |
| 9. Lightheadedness | 25. Ulcers | 41. Blood disorders |
| 10. Frequent urination | 26. Change in bowel habits | 42. Venereal diseases |
| 11. Rheumatic fever | 27. Unexplained weight gain/loss | 43. Anxiety |
| 12. Asthma | 28. Hemorrhoids | 44. Depression |
| 13. Bronchitis | 29. Gall bladder disease | 45. Anemia |
| 14. Pneumonia | 30. Colitis | 46. Alcohol abuse |
| 15. Persistent cough | 31. Hepatitis or Jaundice | 47. Drug abuse |
| 16. T.B. | 32. Thyroid disease | 48. Gout |

NOTES:

Patient Signature: _____

Date: _____

Reviewed by: _____

Date: _____