Providence Medical Group Southeast

Adult History (18+)

Name	Date of Birth	Age	Date

What concerns do you have about your health that you want to discuss today?

Do you have any major medical illnesses: Yes_____ No ____ Please list:

Have you been hospitalized overnight in the past year? Yes ____-No_____ Please list reasons:

Have you had any surgeries? Yes____ No _____ Please list:

Are you currently taking any medications: Yes _____ No _____ Please list:

Medication	Dose	How many times per day	When started

Do you have any drug allergies Yes _____ No _____ Please list:

General Health Questions: (please circle any you've had over the last 3 months

Skin rashes	Frequent or severe headaches	Seizures
Dizziness	Ear problems	Difficulty swallowing
Eye problems	Trouble breathing	Wheezing
Frequent coughing	High Blood Pressure	Swollen legs
Chest pains	Stomach pains	Diarrhea
Nausea or vomiting	Feel like you are constantly going to the bathroom to urinate (pee)	Constipation
Problems urinating	A change of 15 lbs or more in your weight	Trouble walking
Always feel thirsty	Pain	Trouble controlling anger
Arthritis	Worried or anxious	Sexual problems
Depressed	Increased bruising/bleeding compared to what you are used to?	Trouble sleeping
Sinus problems	Lots of fevers	Blood in stool

For women only

When was your last Pap test? _____ When was your last mammogram? _____

Have you EVER had a Pap test or Mammogram that wasn't normal? Yes _____ No _____

Pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____

1st day, most recent period _____ Age at 1st period _____ Regular or Irregular _____

Do you have any concerns about your periods? Yes _____ No _____

Do you have any concerns about menopause? Yes _____ No _____

Social history

Occupation:	Employer:
Years of Education/Highest Degree	Marital Status: S M D W Other
Spouse/Partner's name	Number of children/ages:
Who lives at home with you?	

Family History

Please indicate the current status of your immediate family members:

		Alive	Deceased	Age (now or at death)	Comments/Cause of Death
Mother					
Father					
Sister(s)	#				
Brother(s)	#				

Health/Safety History

Tobacco Use	CAFFEINE Intake: None Coffee Tea Cups/day
Cigarettes Never Quit: Date	# sodas/day Chocolate oz/day
Current Smoker packs/day # of years	WEIGHT: Are you satisfied with your weight? Yes No
Other tobacco: Pipe Cigar Snuff Chew	DIET: How do you rate your diet? Good Fair Poor
Are you interested in quitting? Yes No	Do you take SUPPLEMENTS?
Alcohol Use	Do you drink 4 lg glasses of milk daily or take CALCIUM supplements? Yes No
Do you drink alcohol? Yes No # drinks/week	EXERCISE: Do you exercise regularly? Yes No
Are you or anyone else concerned about your alcohol use? Yes No	What kind of exerciser?
Drug Use	How long? (minutes) How often?
Have you ever used recreational drugs? Yes No	BIKE HELMET Do you wear a bike helmet? Yes No
Sexual Activity	SEAT BELT: use seatbelts consistently? Yes No
Have you ever had sex? Yes No	Is VIOLENCE at home a concern for you? Yes No
Current sex partner(s) is/are: Male Female	Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? Yes No
Birth control method: None needed	Do you feel safe in your current relationship/ Yes No
Have you ever had any sexually transmitted diseases (STDs)? Yes No	Is there a partner from a previous relationship who is making you feel unsafe now? Yes No
Are you interested in being screened for sexually transmitted diseases? Yes No	Do you have a GUN in your home? Yes No