PMG North Portland Family Medicine

PROVIDENCE Health & Services

4920 N. Interstate Ave.
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ADULT HISTORY (18+)

NAME:	DATE OF BIRTH:	AGE:	Today's DATE:

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

Past Medical History (i.e. elevated BP, diabetes etc.) **Date of Onset:** **Resolved**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Hospitalization (outside of surgeries and pregnancies): **Year** **Any Complications?**

_____ _____ _____
_____ _____ _____
_____ _____ _____

Surgery History: **Year** **Any Complications?**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Specialists

Name of Specialist	Specialty	What were/are you treated for?	When was specialist last seen?	What medications do they prescribe for you?

Medications

Medication	Dose	How many times per day?	When Started?

Any Known Drug Allergies? _____ YES (Please list) ____ NO

_____ _____
_____ _____

Preventive care history – please mark whether you have had any of the following screening tests (these may or may not be needed, depending on your age and history):

Pap smear to screen for cervical cancer – most recent date: _____

Result: _____ **Further treatment needed:** _____

Any history of abnormal pap smears? If so, when? _____

Any treatments needed because of an abnormal pap smear (if so, what and when?) _____

Mammogram to screen for breast cancer? _____**YES** _____**NO Year** _____

What were the results? _____

Where was it done?_____

Colonoscopy to screen for colon cancer? _____**YES** _____**NO Year** _____

What were the results? (were there polyps?)_____

Who performed the colonoscopy?_____

Blood test (PSA) or prostate exam to screen for prostate cancer? _____**YES** _____**NO Year** _____

What were the results? _____

Bone density test to screen for osteoporosis? _____**YES** _____**NO Year** _____

What were the results? _____

Where was it done?_____

Lung CT to screen for lung cancer (if so, when and what were the results?) _____

Ultrasound to screen for aortic aneurysm (if so, when and what were the results?) _____

Blood tests to screen for high cholesterol and/or diabetes if so, when and what were the results?)_____

_____

Immunization history – please check whether you have had any of these vaccines (and provide the years, if you know them):

Tetanus (Td) or Tetanus/Pertussis (Tdap) _____

Pneumococcal (pneumonia) _____

Influenza (flu) _____

Hepatitis A _____

Hepatitis B _____

Herpes zoster (shingles) _____

HPV (humanpapillomavirus) _____

Meningococcal (meningitis) _____

FOR WOMEN ONLY:

Pregnancies:_____ # Deliveries:_____ # Abortions:_____ # Miscarriages:_____

1st day of your most recent period: _____ Age @ 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:_____

If not currently working, what did you do in a previous job?

_____

Highest level of Education/ Degree_____

Marital Status: Single___ Married___ Divorced___ Widowed___ Other_____

Spouse/Partner's name (if applicable):_____Number of Children/Ages:_____

Who lives at home with you?_____

_____

Hobbies: List 3 things you enjoy doing or have a passion for _____

_____

HEALTH / SAFETY HISTORY:

Tobacco Use:

Cigarettes: **Yes No NEVER**

____Current Smoker: packs/day____ # years_____

Quit **?**___ / Date_____

Other Tobacco: Pipe___ Cigar___ Snuff___ Chew____

Are you interested in Quitting? **Y N**

Alcohol Use:

Do you drink Alcohol?: **Yes No** #drinks/Week_____

Drug Use:

Have you ever used recreational drugs? **Yes No**

Do you currently use any recreational drugs? **Yes No**

Which one(s)?

Any history of using IV drugs?

Sexual Activity:

Have you ever had sex? **Yes No**

Current sex partner(s) is/are: ___Male ___Female

Birth Control Method: _____ None needed ___

Have you ever had any sexually transmitted diseases?

Yes No

Safety

Is **violence** at home a concern? **Yes No**

Do you feel **unsafe** in your current relationship?

Yes No

Have you been hit, kicked, punched or otherwise hurt by someone in the past year? **Yes No**

Do you have a **gun** in your home? **Yes No**

Do you use a bike helmet? **Yes No N/A**

Do you use seatbelts consistently? **Yes No**

Weight and exercise

Are you satisfied with your weight? **Yes No**

Do you exercise regularly? **Yes No**

What kind of exercise?_____

_____

How long (minutes)?_____ How often?_____

Family History

Please provide us with some health information about your immediate family members

Your Mother ☐ **unknown**

☐ Alive? ☐ Died? Age at death. _____ What did she die of? _____

Did your mother have any of the following illnesses:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Heart Failure ☐ Thyroid Problems
☐ Depression ☐ Alcohol Problems ☐ Drug Problems ☐ Cancer, type _____ ☐ Asthma

Your Father ☐ **unknown**

☐ Alive? ☐ Died? Age at death. _____ What did he die of? _____

Did he have any of the following illnesses:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Heart Failure ☐ Thyroid Problems
☐ Depression ☐ Alcohol Problems ☐ Drug Problems ☐ Cancer, type _____ ☐ Asthma

Your Maternal Grandmother (mother's mother) ☐ **unknown**

☐ Alive? ☐ Died? Age at death. _____ What did she die of? _____

Did she have any of the following illnesses:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Heart Failure ☐ Thyroid Problems
☐ Depression ☐ Alcohol Problems ☐ Drug Problems ☐ Cancer, type _____ ☐ Asthma

Your Maternal Grandfather (mother's father) ☐ **unknown**

☐ Alive? ☐ Died? Age at death. _____ What did he die of? _____

Did he have any of the following illnesses:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Heart Failure ☐ Thyroid Problems
☐ Depression ☐ Alcohol Problems ☐ Drug Problems ☐ Cancer, type _____ ☐ Asthma

Your Paternal Grandmother (father's mother) ☐ **unknown**

☐ Alive? ☐ Died? Age at death. _____ What did she die of? _____

Did she have any of the following illnesses:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Heart Failure ☐ Thyroid Problems
☐ Depression ☐ Alcohol Problems ☐ Drug Problems ☐ Cancer, type _____ ☐ Asthma

Your Paternal Grandfather (father's father) ☐ **unknown**

☐ Alive? ☐ Died? Age at death. _____ What did he die of? _____

Did he have any of the following illnesses:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Heart Failure ☐ Thyroid Problems
☐ Depression ☐ Alcohol Problems ☐ Drug Problems ☐ Cancer, type _____ ☐ Asthma

Your Brother(s) **☐ unknown**

☐ Alive? ☐ Died? Age at death. _____ What did he die of? _____

☐ Alive? ☐ Died? Age at death. _____ What did he die of? _____

☐ Alive? ☐ Died? Age at death. _____ What did he die of? _____

Did any of your brothers have any of the following illnesses:

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Heart Failure	☐ Thyroid Problems
☐ Depression	☐ Alcohol Problems	☐ Drug Problems	☐ Cancer, type _____	☐ Asthma

Your Sister(s) **☐ unknown**

☐ Alive? ☐ Died? Age at death. _____ What did she die of? _____

☐ Alive? ☐ Died? Age at death. _____ What did she die of? _____

☐ Alive? ☐ Died? Age at death. _____ What did she die of? _____

Did any of your sisters have any of the following illnesses:

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Heart Failure	☐ Thyroid Problems
☐ Depression	☐ Alcohol Problems	☐ Drug Problems	☐ Cancer, type _____	☐ Asthma

Other Relatives? ***Relation*** _____

☐ Alive? ☐ Died? Age at death. _____ What did s/he die of? _____

Did your relative have any of the following illnesses:

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease	☐ Heart Failure	☐ Thyroid Problems
☐ Depression	☐ Alcohol Problems	☐ Drug Problems	☐ Cancer, type _____	☐ Asthma