ADULT HEALTH DATABASE

Name:
D.O.B.: Date:

Please review the **MEDICAL SUMMARY** you were given at check-in.
THIS IS YOUR PERMANENT MEDICAL RECORD
Please correct any mistakes and add anything missing

Specifically, please confirm since your last health maintenance exam here:

1. Hospitalization? ☐No ☐Yes ____
2. Surgery? ☐No ☐Yes ____
3. Allergic reaction? ☐No ☐Yes ____
4. Major illness/accident? ☐No ☐Yes ____
5. Immunizations? ☐No ☐Yes ____

If not listed in your medical summary, please confirm whether you:

1. smoke? ☐No ☐Yes – how much? ______________________________
2. exercise? ☐No ☐Yes – what type? ______________ how often? _________
3. follow a special diet? ☐No ☐Yes – what? ___________________________________
4. drink alcohol? ☐No ☐Yes – how often? ______________________________
5. use other drugs? ☐No ☐Yes ____
6. have an Advance Directive (living will and durable power of attorney for health care)? ☐No ☐Yes
   Name of Healthcare Proxy/Durable Power of Attorney for healthcare: ______________________
   If you have an Advance Directive (Living Will, Health Care Proxy) please provide us with a copy.
   If you would like more information, please ask.

Have you received preventative health care we are not aware of? Specifically:

Have you undergone?	**Date of last**	**Results**	**Would you like to discuss?**
Physical Exam			
Pap Smear			
Mammogram			
Colonoscopy			
Other test for colon cancer			
Eye Exam			
Hearing Exam			
Dental Exam			
Cholesterol Screening			
Prostate cancer blood test(PSA)			
Bone mineral density test			
Testing for HIV/AIDS/Hep C			

PLEASE COMPLETE OTHER SIDE OF FORM

Are there any questions you wish answered today if there is time?

Do you need medication refills today? YES NO

Are there any forms you request to be completed today? YES NO

Would you like a nurse to accompany you during your visit today? YES NO

Please indicate if you are having any of the following symptoms:

Constitutional	**Old**	**New**
Feeling tired		
Fever / Chills		
Recent weight change		
Eyes	**Old**	**New**
Visual changes		
Red eyes		
Ear, Nose, Throat, Mouth	**Old**	**New**
Ear pain		
Nasal congestion/Post-nasal drip		
Sore throat		
Sores in mouth		
Cardiovascular	**Old**	**New**
Chest painful or tight		
Palpitations / racing heart		
Swelling in feet or ankles		
Respiratory	**Old**	**New**
Coughing		
Wheezing		
Shortness of breath		
GI	**Old**	**New**
Decreased appetite		
Abdominal pain		
Nausea or vomiting		
Diarrhea		
Constipation		
Heartburn		
Blood in stool		
Urinary	**Old**	**New**
Pain during urination		
Frequency of urination		
Blood in urine		
Musculoskeletal	**Old**	**New**
Neck pain		
Back pain		
Joint pain		
Skin	**Old**	**New**
Skin rash		
Changing mole		
Neurologic	**Old**	**New**
Headache		
Dizziness		
Numbness		
Decrease in strength		
Psychiatric	**Old**	**New**
Sleep disturbances		
Depression		
Anxiety		
Endocrine	**Old**	**New**
Excessive sweating		
Sweating heavily at night		
Excessive thirst		
Feeling hot or cold		
Hem/Lymph	**Old**	**New**
Easy bruising		
Swelling		
Allergies	**Old**	**New**
Food allergies		
Seasonal allergies		
Gynecological (women only)	**Old**	**New**
Irregular vaginal bleeding		
Vaginal discharge		
Vaginal pain, itching or burning		
New/changing breast lump		

PLEASE COMPLETE OTHER SIDE OF FORM