

ADULT HEALTH DATABASE

Date:		

Name:	DOB:	Previous L	ast Name (?):	
Address:				
Phone (Please Circle Preferred Contact #			Work	
Race (Optional): E	nil:		oary Languago :	
Emergency Contact: Name:E	unificity (Optional)	elationshin:	Dhone	
Emergency Contact. Name.		elationship	1 110116	
MEDICATIONS – Please include prescription and vitamins, laxatives, birth-cont	d non-prescription 1	medications used or	n a regular basis (Inc	luding aspirin,
	ALLERGIES / S	ENSITIVITIES:		
Drug or Substance Reaction When did you have				
HEALTH HISTORY – please	list any medical condition	ons, pertinent informatio	on, and any specialists you	ı see for them
Condition(s):	Specialist:	Condit	ion(s):	Specialist:
			I	
	SURGICAL	L HISTORY		
Surgery:	Date:	S	urgery:	Date
<u>0</u>	VERNIGHT HOS	SPITALIZATIONS	<u>S:</u>	
Reason	Date(s)	F	Reason	Date(s)

FAMILY HEALTH HISTORY

	Alive?	DOB -or Age at Death	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness/ Mood Disorder	Cancer (& Type)	Alcohol/ Substanc Abuse	Migraine	Other? Please Specify
Father									7 02 7		
Mother											
Paternal Grandfather											
Paternal Grandmother											
Maternal Grandfather											
Maternal											
Grandmother Brother / Sister											
Brother / Sister											
Brother / Sister											
Brother / Sister											
Children # = ()											
A 11'.' 1 D 1 .' /T											
Additional Explanations/In PERSONAL HISTORY	nto:										
Current Marital Status:			Г	∃ Single	□ Maı	rried	□ Separat	ted □	Divorced	□ 1	Vidowed
Do you currently use toba	cco?		Г	_			Smoke [
Do you currently use toou	cc o.		L				day?			_	
Smaltad / aboved		-a+9	-								
Smoked / chewed	-			□ No			late you quit				
How much alcohol do you		1K ?					drinks of				
Caffeine consumed regula	-						nuch daily?				
How much marijuana do y				None			ke/use/take _				
Have you used recreationa	ıl drı	ıgs?		□ No		urre	nt 🗆 Past (Quit D	ate):		
			7	What kind	and hov	v mu	ch/frequent?				
Do you exercise regularly	?			□No □Y	es: Typ	e an	d frequency:				
Do you follow any special	diet	:?		□No □Y	es Typ	e:					
Highest Education Level:							ge □Grad-				
Current Occupation:											
Military History: □N/A											
Birthplace:											
Hobbies:											
Sexual Activity:											
What is your gender ident	itv?			$\sqcap M$	ale ⊓F	ema.	le □Trans	□Othe	r:		
Your past sexual partners	•	been·					le □Trans				
Have you recently (past 5)						1114			••		Yes □No
						sitta -	l digaga/ I4	Continu			
Have you ever been treate	u 101	venereal (nsea	se/sexuall	y transn	пиес	i disease/ ini	ection?		Ш	Yes □No

 \square None, N/A

WITH WHOM DO YOU LIV	E?						
Name Age	Relationshi	p Any re	Any recent major changes in family/personal life?				
1		\text{\text{\$\sum Yes}}	□No				
2							
3							
4							
5							
6							
IMMUNIZATION STATUS	41 4 :	9 DVaa DNa					
Did you receive all of your chil Have you			of last	Results			
Tetanus (last booster)	nau:	Date	UI IASL	Results			
Pneumovax (pneumonia) – <i>If o</i>	ver age 65. or Diah	etic					
Prevnar – <i>If over age 65</i>	10. 11.90 00, 01 21.110						
Zostavax/Shingles – If over age	2.60						
<u> </u>							
SAFETY Do you feel safe in your curren Are you, or have you been, a vi ADVANCE DIRECTIVE Do you have and "Advanced D Do you have a Durable Power of If so, please provide our office OB GYN HISTORY- WOME Are you going to be receiving of Last period date: Number of pregnancies: Last PAP among data?	ctim of abuse? irective" for healther of Attorney? with copies. EN ONLY GYN care at our off If post-menopau Number of births:	care? ice? se, your period h	as stoppe				
Last PAP smear date?	If you see	GYN elsewhere,	, whom d				
Have you ever had an abnorma	i pap?			□Yes □No			
GENERAL HEALTH MAIN	TENANCE						
Have you undergone?	Date of last	Results		Would you like to discuss?			
Physical Exam							
Mammogram							
Colonoscopy							
	1	· —					

Have you undergone? Date of last Results Would you like to discuss? Physical Exam Mammogram Colonoscopy Other test for colon cancer Cholesterol Screening Diabetes Screening Prostate cancer blood test(PSA) Bone mineral density test

			4					
Please Rate your overall health for your age on a 0-10 scale from 0 (Awful Health) to 10 (Perfect Health):	Name:	_	44		ADULT HEALTH DATABASE			
Please Rate your overall health for your age on a 0-10 scale from 0 (Awful Health) to 10 (Perfect Health):	D.O.B.: Date:							
Do you need medication refills today? Y/N	•		e on a 0-1	0 scale from 0 (Aw		Perfect Heal	th):	
Do you have forms that need to be filled out today?	In the last two weeks have you been	n bothered l	•		~ ~			
Do you have forms that need to be filled out today?	Do you need medication refills toda	y?				Y / N		
YOUR most important health QUESTION to be answered? Do you have some PERSONAL GOALS for your health? Please Indicate if you are having and would like to discuss any of the following symptoms: Constitutional Old New Excessive Fatigue Pain during urination Fever / Chills Recent weight change Blood in urine Blood in urine Sexual/Erectile/Libido Trouble Skin Changing moles Eyes Skin Rash Changing moles Eyes Skin Rash Neurologic Headache Nasal Congestion/post nasal drip Dizziness Numbness Sore Throat Dizziness Numbness Decrease in strength Paychiatric Depression Anxiety Swelling in feet or ankles Endocrine Excessive sweating Sweating Heavily at Night Excessive thirst Peeling abnormally hot or cold Hem/Lymph Bodards Allergies Productions of the Constipation Seasonal allergies Generous Musculoskeletal Placeton Irregular vaginal bleeding Vaginal Discharge Nusculoskeletal Production of the following symptoms: Genitourinary Genitourinary Old New Pain during symptoms: Genitourinary Old New Pain during urination Pain during urination Pain during urination Pain during urination Sexual/Erectile/Libido Trouble Sexual/Erectile/Libido Trouble Sexual/Erectile/Libido Trouble Sexual/Erectile/Libido Trouble Sexual/Erectile/Libido Trouble Skin Changing moles Sexual/Erectile/Libido Trouble Skin Pain during urination Prequency of urination Prequency of urination Prequency of urination Pain during urination Pain during urination Prequency of urination Pain during ur		*	day?			Y / N		
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Blood in stool Irregular vaginal bleeding Musculoskeletal Vaginal Discharge								
Musculoskeletal Vaginal Discharge								
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**Beyond your preventive care please list additional questions you want addressed if possible:

New/changing breast lump

Back Pain

Joint Pain



Preventive Care Coverage versus Medical Care Coverage

Many insurance companies now cover preventive care services without copays or deductibles. These services typically include an annual preventive visit, routine vaccines and screenings for medical conditions such as cancer, high cholesterol and diabetes. Insurance companies follow national guidelines that do not consider some medication refills, monitoring chronic conditions or assessing and managing *new* symptoms as preventive care. For insurance purposes, these services are treated as two separate visits and must be billed as such.

For your convenience, we often complete both of these services at one office visit. However, if we discuss chronic medical conditions (refill medications, monitor labs, etc) or manage new symptoms (knee pain, cough, rash, etc) at a preventive visit you may be subject to whatever co-pay or deductible your insurance requires for a routine medical office visit.

In summary: You can schedule both types of services together, but please be aware that your insurance will likely consider these two separate visits on the same day.

Here are some typical examples (but confirm with your own insurance):

Preventive Visit

Annual wellness visit Screening cholesterol Mammography

Routine Medical Care

medication refills lab work for chronic condition x-rays to diagnose symptoms