EVERGREEN
FAMILY HEALTH

ADULT HEALTH DATABASE

Date:_____

Name: _____ DOB: _____ Previous Last Name (?): _____
Address: _____
Phone (Please Circle Preferred Contact #): Cell _____ Home: _____ Work_____
Email: _____
Race (Optional): _____ Ethnicity (Optional):_____ Primary Language :_____
Emergency Contact: Name: _____ Relationship: _____ Phone: _____

MEDICATIONS – Please bring all medication bottles with you to your first visit

*** Please include prescription and non-prescription medications used on a regular basis (Including aspirin, vitamins, laxatives, birth-control, injections, alternative medicines, etc.) Add extra sheet if needed.

Medication Name:	Dose:	Frequency:	Used for:

ALLERGIES / SENSITIVITIES:

Drug or Substance	Reaction	When did you have reaction?

HEALTH HISTORY – please list any medical conditions, pertinent information, and any specialists you see for them

Condition(s):	Specialist:	Condition(s):	Specialist:

SURGICAL HISTORY

Surgery:	Date:	Surgery:	Date

OVERNIGHT HOSPITALIZATIONS:

Reason	Date(s)	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/ Substance Abuse	Migraine	Other? Please Specify
Father											
Mother											
Paternal Grandfather											
Paternal Grandmother											
Maternal Grandfather											
Maternal Grandmother											
Brother / Sister											
Brother / Sister											
Brother / Sister											
Brother / Sister											
Children # = ( )											

Additional Explanations/Info: _____

PERSONAL HISTORY

Current Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Do you currently use tobacco? □ No □ Yes: □ Smoke □ Chew □ Vape/E-CIG

How much per day? _____

Smoked / chewed in past? □ No □ Yes: date you quit: _____

How much alcohol do you drink? □ None □ _____ drinks of _____ per _____

Caffeine consumed regularly? □ None □ How much daily? _____

How much marijuana do you use? □ None □ I smoke/use/take _____ per _____

Have you used recreational drugs? □ No □ Current □ Past (Quit Date): _____

What kind and how much/frequent? _____

Do you exercise regularly? □No □Yes: Type and frequency: _____

Do you follow any special diet? □No □Yes Type: _____

Highest Education Level: □ Elem □HS □College □Grad-Degree: _____

Current Occupation: _____ Current Employer: _____

Military History: □N/A □ Yes (explain): _____

Birthplace: _____ Religion: _____

Hobbies: _____

Sexual Activity:

What is your gender identity? □Male □Female □Trans □Other: _____

Your past sexual partners have been: □Male □Female □Trans □Other: _____

Have you recently (past 5yrs) had multiple sexual partners? □Yes □No

Have you ever been treated for venereal disease/sexually transmitted disease/ Infection? □Yes □No

Birth control method(s) including vasectomy or "tubes tied": _____ □None, N/A

WITH WHOM DO YOU LIVE?

Name	Age	Relationship
1.		
2.		
3.		
4.		
5.		
6.		

Any recent major changes in family/personal life?
□Yes □No _____
_____
_____
_____
_____
_____

IMMUNIZATION STATUS

Did you receive all of your childhood vaccinations? □Yes □No

Have you had?	Date of last	Results
Tetanus (last booster)		
Pneumovax (pneumonia) – *If over age 65, or Diabetic*		
Prevnar – *If over age 65*		
Zostavax/Shingles – *If over age 60*		

SAFETY

Do you feel safe in your current living situation and current relationships? □Yes □No
Are you, or have you been, a victim of abuse? □Yes □No

ADVANCE DIRECTIVE

Do you have and "Advanced Directive" for healthcare? □Yes □No
Do you have a Durable Power of Attorney? □Yes □No
If so, please provide our office with copies.

OB GYN HISTORY- WOMEN ONLY

Are you going to be receiving GYN care at our office? □Yes □No
Last period date: _____ If post-menopause, your period has stopped in what year: _____
Number of pregnancies: ____ Number of births: _____
Last PAP smear date? _____ If you see GYN elsewhere, whom do you see?_____
Have you ever had an abnormal pap? □Yes □No

GENERAL HEALTH MAINTENANCE

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			

Name:
D.O.B.: Date:

EVERGREEN
FAMILY HEALTH

ADULT HEALTH DATABASE

Please Rate your overall health ***for your age*** on a 0-10 scale from 0 (Awful Health) to 10 (Perfect Health):

←0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10→

In the last **two weeks** have you been bothered by: Little interest or pleasure in doing things? ☐ Yes ☐ No

Feeling down, depressed or hopeless? ☐ Yes ☐ No

Do you need medication refills today?	Y / N
Do you have forms that need to be filled out today?	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		
Fever / Chills		
Recent weight change		
Sleep Disturbances/Apneas		
Eyes		
Visual changes		
Red Eyes		
Ear, Nose, Throat, Mouth		
Ear Pain		
Nasal Congestion/post nasal drip		
Sore Throat		
Sores in Mouth		
Cardiovascular		
Chest painful or tight		
Palpitations / racing heart		
Swelling in feet or ankles		
Respiratory		
Coughing		
Wheezing		
Shortness of breath		
GI		
Decrease in appetite		
Abdominal pain		
Nausea or vomiting		
Diarrhea		
Constipation		
Heartburn		
Blood in stool		
Musculoskeletal		
Neck Pain		
Back Pain		
Joint Pain		

Genitourinary	**Old**	**New**
Pain during urination		
Frequency of urination		
Blood in urine		
Sexual/Erectile/Libido Trouble		
Skin		
Changing moles		
Skin Rash		
Neurologic		
Headache		
Dizziness		
Numbness		
Decrease in strength		
Psychiatric		
Depression		
Anxiety		
Endocrine		
Excessive sweating		
Sweating Heavily at Night		
Excessive thirst		
Feeling abnormally hot or cold		
Hem/Lymph		
Easy bruising		
Swollen Glands		
Allergies		
Food allergies		
Seasonal allergies		
Gynecological (women)		
Irregular vaginal bleeding		
Vaginal Discharge		
Vaginal pain, itching or burning		
New/changing breast lump		

****Beyond your preventive care please list additional questions you want addressed if possible:**

_____

_____

_____

EVERGREEN
FAMILY HEALTH

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