Adult Medical History and Review of Systems Questionnaire

Confidential

Patient Name_____ Date of Birth_____/_____/_____Age_____

SSN_____Home Phone_____Work Phone_____

Cell Phone_____Email_____

Address_____City_____State_____Zip_____

Height_____ Weight_____ Family Physician/PCP_____

Current Pharmacy_____ Location_____Pharmacy Phone # _____

Are you presently working or going to school full or part time? _____

Employer / School: _____

Emergency Contact _____Contact Phone #_____

Release of Records

May we leave a message about test results on your voice mail or answering machine? __Yes __No

May we email you about test results? __Yes __No

Who may have access to your medical records?

Name	**Relation**	**Contact Information**

How did you hear about us? (*Please circle all that apply*)

DOCTOR or PATIENT REFERRAL (*who*) _____ HOSPITAL REFERRAL LINE

WORD OF MOUTH WEBSITE SEARCH ENGINE (LIKE GOOGLE) MY INSURANCE COMPANY

Have you seen any other **Medical** Specialists in the past 24 months? __Yes __No If yes, please list them:

_____

Insurance Precertification: Do you have health coverage that you will be using for this visit? __Yes __No

Are you the primary policy holder? __Yes __No If no, who is?_____

How are they related to you?_____What is their Date of Birth? _____/_____/_____

Patient Name____ Date of Birth_____/_____/_____

1. **<u>Allergies</u>:** (*Circle all that apply*) SULFA PENICILLIN TETRACYCLINE CIPRO IODINE

Are you allergic to any other medicines? __Yes __No If yes, Please list them: _____________________

Are you allergic to latex? __Yes __No

Have you ever had problems with anesthesia? __Yes __No

If yes, describe:____

2. **<u>Medicines</u>:** Please list ALL medicines you are currently taking, including over the counter & supplements

Currently Taking (Please list ALL medications, including over the counter and supplements)			
Date	**Medication Name**	**Dose (usually in milligrams)**	**# Times Taken Per Day**

Patient Name_____ Date of Birth_____/_____/_____

3. Operations / Surgical Procedures **Date**

_____

_____

_____

_____

_____

_____

_____

4. Injuries **Date**

_____

_____

_____

_____

_____

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5. Hospitalizations/Medical Illness **Date**

_____

_____

_____

_____

_____

_____

_____

6. Social History:

Do you smoke?___ Number of years?___ Packs Per day?___ If ex-smoker, how long since quitting?___

Use smokeless tobacco? ___ How many years?___ Cans/packs per day?___ If you quit, how long ago?___

Do you drink alcohol? ___ Is it daily/weekly/monthly/quarterly? ___

Beer cans per day?___ Alcohol ounces/shots per day?___ Wine glasses per day? ___ Prior addiction? ___

Do you take or have you taken recreational drugs? ___Yes ___No ___Prior addiction

What kind of work do you do?_____

Marital Status: Married / Single / Widowed / Divorced / Separated

Do you live alone? ____ Who lives with you?_____How many children do you have?___

Patient Name_____ Date of Birth_____/_____/_____

6. Social History (continued):

Does anyone complain that you snore? __Yes __No Do you stop breathing at night? __Yes __No

Do you use CPAP?____Caffeine intake:_____ per day

Do you exercise? __Yes __No Type/Frequency:_____

Are you at risk for AIDS or Hepatitis (e.g. sexual orientation, drug abuse, previous blood transfusion)?

__Yes __No If yes, explain: _____

7. Family History:

Family Member	**Medical Illnesses**	**Living or Deceased?**	**Cause of Death**
Mother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Paternal Grandfather			
Paternal Grand Mother			
Sister(s)			
Brother(s)			

If there was any question above that you did not have enough room for a complete answer, please let us know in the space provided below:

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Patient Name_____ Date of Birth_____/_____/_____

8. Review of Systems:

Are you currently having, or have you had problems with: (check all that apply)

General well-being
__ Fever
__ Weight loss (>10#)
__ Excess fatigue
__ Recurrent Nausea / vomit
__ Night sweats

Eyes
__ Wear glasses
Date of last exam _____
__ Infections
__ Injuries
__ Glaucoma
__ Cataracts
__ Blurred vision
__ Trouble focusing
__ Recent change in vision

Ears, Nose, Mouth and Throat
__ Wear hearing aids
Date of last exam_____
__ Hearing loss
__ Ear infection
__ Pressure in ears
__ Ringing in ears
__ Pain in ears
__ Balance disturbance
__ Itching in ears
__ Dizziness
__ Nasal congestion
__ Nasal drainage
__ Nosebleeds
__ Sinus problems
__ Sinus infections
__ Sinus headaches
__ Throat infections
__ Difficulty swallowing
__ Lip or mouth sores
__ Sore throats

Respiratory
__ Chronic cough
__ Emphysema
__ Bronchitis
__ Asthma
__ Chronic obstruction
__ Pulmonary disease
__ Shortness of breath
__ Oxygen use at home
__ Pneumonia
__ Lung cancer
__ Tuberculosis
__ Blood in saliva
Date of last chest X-ray_____

Cardiovascular
__ Chest pain
Date of last EKG _____
__ Heart attack
__ High blood pressure
__ Low blood pressure
__ Irregular heartbeat
__ Heart murmur
__ Arm and leg swelling
__ High cholesterol

Gastrointestinal
__ Blood in vomit
__ Indigestion
__ Nausea / vomiting
__ Jaundice
__ Abdominal pain
__ Change in bowel habits
__ Ulcers or Gastritis
__ Colon, liver, stomach cancer
__ Hepatitis

Hematologic
__ Anemia
__ Hemophilia
__ Easy bleeding / bruising
__ Swollen glands

Genitourinary
__ Urinary tract infection
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Kidney stones
__ Prostate cancer
__ Endometriosis
__ Uterine, ovarian or cervical cancer

Neurological
__ Disorientation
__ Fainting / blacking out
__ Light headedness
__ Seizures
__ Stroke
__ Mini-stroke
__ Memory problems
__ Concentration problems
__ Speech problems
__ Facial weakness/ spasms
__ Muscle weakness
__ Coordination problems
__ Uncontrolled shaking
__ Headache
__ Migraine

Endocrine
__ Diabetes
__ Hormone problems
__ Low blood sugar
__ Thyroid disease
__ Increased appetite
__ Excessive thirst
__ Excessive urination
__ Temperature intolerance
__ Pituitary gland problems
__ Bleeding tendencies

Immunologic
__ Environmental allergies
__ Hay fever
__ Food allergies
__ Immune system problems
__ Connective tissue disease
__ Frequent colds / infections

Skin
__ Eczema or psoriasis
__ Dermatitis
__ Dry or scaling skin
__ Rashes
__ Changes in skin color
__ Changes in moles
__ Skin cancer
__ Breast pain or swelling
Date of last Mammogram
_____

Musculoskeletal
__ Broken bones
list:_____
__ Arm or leg weakness
__ Joint pain or swelling
__ Back pain
__ Arthritis

Psychiatric
__ Anxiety
__ Depression
__ Manic/Depression
__ Schizophrenia
__ Considering suicide / homicide
__ Panic attacks
__ Sudden mood swings
__ Emotional difficulties
__ Insomnia
__ Other psychiatric problems
__ Under psychiatric care
__ Desiring psychiatric care

The above information is accurate to the best of my knowledge.

_____ _____
Patient Signature *Date*

_____ _____ _____
Legal guardian *relationship* *Date*