Name: _____
DOB: _____

SHOALS
Family Medicine

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Adult Health History for NEW Patients

Your answers on this form will help us get an accurate history of your medical concerns and conditions. Please fill in all pages. If you cannot remember specific details, please provide your best guess with as much information as you can remember. ***If you are uncomfortable with any question, do not answer it***. Thank you!

Main reason for today's visit:
_____
Other concerns:
_____
What are your health goals for the next year?
_____
Where were you getting your care before?
_____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any ***persistent symptoms*** you have had in the past ***few months***. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
□ Weight loss / gain
□ Fatigue/weakness
□ Fall asleep easily
□ Fever, chills
□ No problems

Skin
□ New or change in mole
□ Rash / itching
□ No problems

Breast
□ Breast lump
□ Breast pain
□ Nipple discharge
□ No problems

Ears/Nose/Throat
□ Nosebleeds
□ Trouble swallowing
□ Frequent sore throat
□ Hoarseness
□ Hearing loss
□ Ringing in ears
□ No problems

Eyes
□ Change in vision
□ Eye pain
□ Eye redness
□ No problems

Cardiovascular
□ Chest pain / Discomfort
□ Palpitations (fast or irregular heartbeat)
□ No problems

Respiratory
□ Cough / wheeze
□ Loud snoring / altered breathing during sleep
□ Short of breath with exertion
□ No problems

Gastrointestinal
□ Heartburn or reflux
□ Blood or change in bowel movement
□ Constipation
□ Diarrhea
□ Nausea/Vomiting
□ No problems

Genitourinary
□ Leaking urine
□ Blood in urine
□ Night Time urination
□ Increased frequency
□ Discharge: penis or vagina
□ Erectile Dysfunction
□ No problems

Musculoskeletal
□ Muscle/Joint Pain
□ Back Pain
□ No problems

Endocrine
□ Heat or cold sensitivity
□ No problems

Hematologic/Lymphatic
□ Swollen glands
□ Easy bruising
□ No problems

Neurological
□ Headache
□ Memory loss
□ Fainting
□ Dizziness
□ Numbness / tingling
□ Unsteady gait
□ Frequent falls
□ No problems

Allergic/Immune
□ Hay fever / allergies
□ Frequent infections
□ No problems

Psychiatric
□ Anxiety / stress
□ Easy Irritability
□ Sleep problems

Women Only
□ Pre-menstrual symptoms
□ Menstrual Issues
□ Hot flashes
□ Night Sweats
□ No problems

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IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. (Please refer to the Preventative Health Record for more information.)

□ Tetanus (Td/Tdap) ____ □ Pneumonia/PCV ____ □ Hepatitis B ____ □ Shingles ____
□ Varicella (Chicken Pox) or illness ____ □ Flu ____ □ MMR ____ □ HPV ____
□ Hepatitis A ____ □ Meningitis ____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications (including over the counter), vitamins, home remedies, birth control pills, herbs, inhalers, etc. **Use the back of this form if you need more room.**

□ TAKE NO MEDICATIONS

Medication Name | Dose | How many times per day? | Who Prescribed?

_____
_____
_____
_____
_____
_____

Allergies or intolerance to medications (tell us what reaction you have):

□ NONE
_____
_____

HEALTH MAINTENANCE AND SCREENING TESTS: (Please see patient preventative health record for complete information)

Lipid (cholesterol) *Date* _____ Abnormal? □ No □ Yes
Colonoscopy *Date* _____ Polyp? □ No □ Yes
Women only:
Mammogram *Date* _____ Abnormal? □ No □ Yes
Pap Smear *Date* _____ Abnormal? □ No □ Yes
Bone Density Test (DEXA Scan) *Date* _____ Abnormal? □ No □ Yes

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you ever had (past) any of the following conditions? □ NONE

□ Alcohol / Drug abuse
□ Allergy (Hay Fever)
□ Anemia
□ Anxiety
□ Arthritis (Rheumatoid)
□ Arthritis (Osteoarthritis)
□ Asthma
□ Urinary Problems
□ Blood Clot (leg)
□ Blood Clot (lung)
□ Blood Transfusion
□ Breast Lump (benign)
□ Cancer Breast
□ Cancer Colon
□ Cancer Other Type
□ Cancer Ovarian
□ Cancer Prostate
□ Cataracts
□ COPD/Emphysema
□ Coronary Artery Disease
□ Depression
□ Diabetes Type II
□ Diabetes Type I
□ Diverticulosis
□ Eczema
□ Endometriosis
□ Fibroids
□ Fractures/Broken Bones
□ Gallbladder Disease
□ Heartburn/GERD
□ Glaucoma
□ Gout
□ Heart Attack
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ Hip Fracture
□ Hyperthyroidism
□ Hypothyroidism
□ Irritable Bowel Synd.
□ Kidney Disease / Failure

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□ Kidney Stones
□ Liver Disease
□ Migraine Headaches
□ Osteoporosis
□ Pneumonia
□ Prostate (enlargement)
□ Psoriasis
□ Seizure / Epilepsy
□ Sleep Apnea
□ Stomach Ulcer
□ Stroke

Other (list): _____
_____

SURGICAL HISTORY – Please check off any procedure or surgeries. List any abnormal finding or complications.

□ NONE

Surgical Procedures (Please Indicate Year)

□ Abdominal Surgery _____
□ Appendix removal _____
□ Back Surgery (lumbar) _____
□ Biopsy (location) _____
□ Breast Surgery Circle: Right Left Both _____
□ Colonoscopy _____
□ Coronary Bypass _____
□ Coronary Stent _____
□ EGD (Stomach Endoscopy) _____
□ Cataract _____
□ Gallbladder Removal _____
□ Heart Surgery (other than coronary bypass) _____
□ Hip Surgery (Circle): Right Left Both _____
□ Hysterectomy (Indicate whether ovaries were removed) _____
□ Knee Surgery (Circle): Right Left Both _____
□ LEEP (Cervix Surgery) _____
□ Neck Surgery _____
□ Tubal Ligation ("Tubes Tied") _____
□ Vasectomy _____
□ Sinus Surgery _____
□ Other(list): _____

In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things?
□ No □ Yes
Feeling down, depressed or hopeless?
□ No □ Yes

FAMILY HISTORY – Please fill in relatives who have or have had the following diseases (parents and siblings are most important). If you are adopted or you do not know your family history, you may skip this section.

□ NO KNOWN HISTORY

Alcoholism / Drug abuse_____
Alzheimers / Dementia_____
Asthma_____
Autoimmune Disease_____
Bleeding or Clotting Disorder_____
Cancer Breast_____
Cancer Colon_____
Cancer Other_____
Cancer Ovarian_____
Cancer Prostate_____
Colon Polyp_____
Coronary Artery Disease (heart attack or stents)_____
Depression / Suicide / Anxiety_____
Diabetes (Type I)_____
Diabetes (adult onset)_____
Emphysema (COPD)_____
Genetic Disorder (explain)_____
Glaucoma_____
Heart Disease (CHF)_____
Heart Disease (Other)_____
Hepatitis B or C_____
High Blood Pressure (Hypertension)_____
High Cholesterol_____
Hip Fracture_____
Hypothyroidism / Thyroid Disease_____
Kidney Disease_____
Kidney Stones_____
Macular Degeneration_____
Migraine Headaches_____
Osteoporosis_____

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Stroke_____ _____
Other _____
(list)_____

OTHER HEALTH ISSUES – These issues are vital to your health and well being. We thank you for taking the time to fill this section out to the best of your ability.

Tobacco Use
Do you now or have you ever smoked? □ No □ Yes □ Current
Number of Years: _____
How many packs a day do you/did you smoke? _____
If you have ever tried to quit what methods have you tried?
_____
Other tobacco: _____

Drug Use
Do you currently use or ever used marijuana or recreational drugs?
□ No □ Yes
If yes, which drugs?_____
____
Have you ever used needles to inject drugs? □ No □ Yes

Diet
How would you rate your diet?
□ Good □ Fair □ Poor
Would you like advice on your diet?
□ No □ Yes

Safety
Is violence at home a concern for you? □ No □ Yes

Alcohol Use
Do you drink alcohol? □ No □ Yes
# of drinks/week: ____
□ Beer □ Wine □ Liquor

Exercise
Do you exercise regularly?
□ Yes □ No
What kind of exercise?

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?

(Circle above all that apply) □ Yes □ No
Please provide a copy of any of the above to Dr. Bullard or Dr. Parker if you have completed these.

SOCIAL HISTORY:
Occupation (or prior occupation): _____
(circle one) retired/unemployed/leave of absence/disabled
Employer: _____
Years of education or highest degree: _____
Marital status (circle one): single, partner, married, divorced, widowed, other: _____
Spouse/partner's name: _____
Number of children: _____
Ages if under 18 years: _____
Number of grandchildren: _____

Who lives at home with you? _____
Leisure activities, group involvement, religion, volunteer work, recent travel:
_____
_____
Do you currently have an active spiritual practice or belief system? □ Yes □ No
Describe if you would like:
_____

WOMEN'S HEALTH HISTORY:
Total number of pregnancies: _____ Number of births: _____
Date (month/day if known) of last menstrual period if you are still menstruating: _____
Age at beginning of periods (menstruation): _____
Age at end of periods (menopause): _____

Thank you for taking the time to fill this out!