WESTERN WAYNE PHYSICIANS

Adult History Form

Name: _____ Date of Birth: _____

Age: _____ Sex: ___ Male ___Female

Allergies to any medications, X-ray dues or other substances: ___YES ___NO
(if yes, please list name of allergy and reaction below)

_____

_____

_____

Medical History: (Circle all items that apply to you)

Allergies	Anemia	Arthritis	Back problems	Blood disorder
Cholesterol disorder	Depression	Diabetes	Hearing problems	Heart disease
Heart Murmur	HIV/Hepatitis	Hypertension	Lung Disease	Kidney disorder
Prostate disorder	Seizures	Skin Cancer	Skin problems	Stroke
Stomach/Digestive disorders		Thyroid problem		Vision problems

Cancer (specify type) _____

Other/Additional Information: _____

Social History:

What name would you like to be called? _____

Race:_____ Religious preference: _____

Marital Status: (please chose one) ___Single ___Divorced ___Married __Separated__Widowed

Who do you currently live with? ___ Alone ___ Family ___ Friends ___ Significant other

Do you feel safe at home? ___ YES ___ NO

Current job: _____ Previous job: _____ Highest level of Education: _____

Do you consider yourself: ___ Underweight ___ Normal weight ___Overweight ___ Obese

What kind of exercise do you do? _____ How often? _____

Do you wear seatbelts? ___YES ___ NO

Do you wear sunscreen? ___ YES ___ NO

Do you text while driving? ___ YES ___ NO

Do you drink coffee/soda/ tea? ___ YES ___ NO
If yes, how many cups/cans a day? _____

What type of birth control is used between you and your partner? _____

Alcohol use: ___ Never ___ Rarely ___ Moderate ___ Daily

Tobacco use: ___ Never ___ Quit Currently smoke _____packs/day Year began smoking:_____

Drug use: ___ Never Type/Frequency _____

Excessive exposure at work/home to: ___ Fumes ___ Dust ___Solvent ___ Noise ___ Air-born particles

Occupation/Location: _____

Current Medications: (Please include all prescriptions, over-the counter, vitamins, and supplements)

NAME/DOSE OF MEDICATION	REASON FOR TAKING MEDICATION

Surgeries/Hospitalizations: Please list date and details; circle either surgery or hospitalization for each

DATE	SURG/HOSP	REASON/DETAILS
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	
	SURG/HOSP	

Severe Injuries:

Please list dates and details of any injuries you have ever had: _____

_____

_____

Health Maintenance:

Date of your last colonoscopy? _____ Date of your last pap smear? _____
Date of your last mammogram? _____ Date of your last bone density test? _____
Date of your last eye exam? _____ Date of your last wellness exam? _____

Immunizations:

Date of Tetanus vaccine? _____ Date of TB screening? _____ pos/neg? ____
Date of Hepatitis B series? _____ Date of chicken pox disease or shot? _____
Date of last Pneumonia vaccine? _____ Date of last Flu vaccine? _____
Dates of Gardasil series? _____

Please let us know how you chose our practice?

__ Referred by friend, neighbor, or work colleague. If so, who? _____
__ Referred by another physician. If so, who? _____
__ Referred by a family member. If so, who? _____
__ Public Ad, or Review: _____
__ Insurance Company
__ Other: _____

Family History

Relative	Name	Year of Birth	Health Problems	Age at Death	Cause of Death
Father					
Mother					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Brother					
Brother					
Brother					
Sister					
Sister					
Sister					
Son					
Son					
Son					
Daughter					
Daughter					
Daughter					

Is there any family history of Cancer or other disease in your family? YES NO

If YES, please list here: _____

Present Medical History:

Do you **CURRENTLY** have any issues with the following? (Please circle YES or NO)

Fatigue	YES	NO
Fever	YES	NO
Weight gain > 10lbs.	YES	NO
Weight loss > 10lbs.	YES	NO
Chang e in wart/mole	YES	NO
Itching	YES	NO
New Lesions	YES	NO
Rash	YES	NO
Headache	YES	NO
Visual Disturbances	YES	NO
Hearing Loss	YES	NO
Frequent Colds	YES	NO
Bleeding Gums	YES	NO
Hoarseness	YES	NO
Neck Stiffness	YES	NO
Swollen Glands	YES	NO
Cough	YES	NO
Difficulty Breathing	YES	NO
Wheezing	YES	NO
Breast Mass	YES	NO
Chest pain	YES	NO
Elevated Blood Pressure	YES	NO
Rapid heart beat	YES	NO
Shortness of Breath	YES	NO
Swelling of Limbs	YES	NO
Abdominal Pain	YES	NO
Change in Bowel Habits	YES	NO
Constipation	YES	NO
Diarrhea	YES	NO
Difficulty Swallowing	YES	NO
Heartburn	YES	NO
Rectal Bleeding	YES	NO
Calf pain	YES	NO
Joint Pain	YES	NO
Muscle Cramps	YES	NO
Dizziness	YES	NO
Weakness	YES	NO
Anxiety	YES	NO
Depression	YES	NO
Cold intolerance	YES	NO

Excessive thirst	YES	NO
Excessive Urination	YES	NO
Bruising	YES	NO
Swollen glands	YES	NO
Excessive bleeding	YES	NO

Over the past two weeks, how often have you experienced any of the following concerns?

Little interest or pleasure in doing things?	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless?	Not at all	Several Days	More than half the days	Nearly every day

MALE ONLY

Difficulty Urinating	YES	NO
Impotence	YES	NO
Urinating during night	YES	NO
Testicular Mass	YES	NO
Penial discharge	YES	NO
Urgency of urination	YES	NO

FEMALE ONLY

Absence of Menstruation	YES	NO
Pain with sex	YES	NO
Pain with Urination	YES	NO
Frequency of Urination	YES	NO
Loss of bladder control	YES	NO
Menstrual issues	YES	NO
Pelvic pain	YES	NO
Vaginal bleeding (other than menstrual)	YES	NO
Vaginal Discharge	YES	NO

Patients over 65 years old

I have fallen in the last year	YES	NO
I use or have been advised to use a cane Or walker?	YES	NO
Sometimes I feel unsteady when I am walking.	YES	NO
I steady myself by holding onto something (e.g.; furniture, wall, etc.) when walking at home.	YES	NO
I am worried about falling?	YES	NO
I need to push with my hands to stand from a chair?	YES	NO
I have some trouble stepping up onto a curb.	YES	NO
I often have to rush to the toilet.	YES	NO
I have lost some feeling in my feet.	YES	NO
I take medicine that sometimes makes me feel lightheaded or more tired than usual.	YES	NO