WFMA

Waynesboro Family Medical Associates, LLP

ADULT HEALTH HISTORY

(Use for ages 21 and over)

Your answers on this form will help your provider understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you.**

Patient Name:____Today's Date:____________

Date of Birth:_________ Age:_____ How would you rate your general health? __Excellent __Good __Fair __ Poor

Main reason for today's visit:____

Other concerns I would like to discuss today:____

REVIEW OF SYSTEMS - Please check any CURRENT symptoms you have:

General
__ Recent fevers/sweats
__ Unexplained weight loss/gain

Lungs/Respiratory
__ Cough/wheeze
__ Coughing up blood

Skin
__ Rash
__ New or change in mole

Eyes
__ Change in vision

Gastrointestinal
__ Heartburn/reflux
__ Blood or change in Bowel movements
__ Nausea/vomiting/diarrhea
__ Abdominal pain

Neurological
__ Headaches
__ Memory Loss
__ Fainting/falling

Ears/Nose/Throat/Mouth
__ Difficulty hearing/ringing in ears
__ Hay fever/allergies/congestion
__ Trouble swallowing

Genitourinary
__ Painful/Bloody urination
__ Leaking urine/weak urine stream
__ Nighttime urination
__ Discharge: Penis or Vagina
__Unusual vaginal bleeding
__Concern with sexual function

Psychiatric/Emotional
__ Anxiety/Stress
__ Sleep problems

Heart/Cardiovascular
__Chest pains/discomfort
__Palpitations
__Short of breath with activity

Blood/Lymph
__Unexplained lumps
__ Easy bruising/bleeding

Breast
__Breast lump
__Nipple Discharge

Musculoskeletal
__Muscle/joint pain
__Recent back pain

Endocrine
__ Cold/heat sensitive
__ Increased thirst/appetite

In the past month, have you had little interest in doing things, or felt down, depressed or hopeless?
___ Yes ___ No

Signature of person completing this form:____

Reviewed by provider:____

ADULT HEALTH HISTORY

Patient name:____ Date:______________

PERSONAL MEDICAL HISTORY: Please note if you have any of the following medical problems
__ Heart disease: High blood pressure __ High cholesterol __ Diabetes __ Cancer
Specific type: _____ Thyroid problem __ Heart attack __ Kidney Disease Type:
Asthma/Lung disease __ Other (specify):

SURGICAL HISTORY: Please list all prior operations (with dates)

____

FAMILY HISTORY: Please note family members (mother, father, sister, brother, aunt, uncle, grandparents)

Alcoholism_________________________
Cancer (type)_______________________
Heart disease_______________________
Depression/Suicide___________________
Genetic disorders____________________
Diabetes____________________________

High cholesterol_______________________
High blood pressure____________________
Stroke________________________________
Bleeding/clotting disorder_______________
Asthma/COPD_________________________
Other_______________________________

SOCIAL HISTORY:

Tobacco use: _Never _Quit date:___
_Current smoker: packs/day__ # of years__
Other tobacco: _Pipe _Cigar _Snuff _Chew
Plan to quit? _Now _Sometime later _No/never

Alcohol use:
Do you, or any household members drink alcohol?
_ No _ If yes, who?__________ _Socially
drinks/week________________

Drug use/addiction:
Do you or any household member use illegal drugs?
_No __If yes, who?________________
Name of drug?___________________
Does anyone in your household have an addiction to drug or prescription medication?
_No _If yes, who?_________________
Name of drug/medication_________________

Do you have a completed living will or Power of attorney for health care?
__Yes __No

OTHER CONCERNS:

Caffeine use: _None _Coffee/Tea/Soda ___
Weight: Are you satisfied with your weight?
__Yes __No
Diet: How do you rate your diet?
__Good __Fair __Poor
Exercise: Do you exercise regularly? _Y _N
If yes, how often? _____ What kind? _____
How often?_____ Minutes per day?______
Safety: Do you use a bike/motorcycle helmet?
__NA __No __Yes
Do you regularly wear seatbelts? _Y _N
Is there violence in the home? _No _Yes
Have you ever been abused? _No _Yes
Do you have a gun in your home? _N _Y
Sexual Activity:
Sexually active? _Yes _No
Current sex partner(s) is/are: _Male _Female
Birth control method______ __None
Have you ever had any STDS? _ Yes _ No
Interested in being screened for STDs?____

Signature of person completing this form:____
Reviewed by provider:____

ADULT HEALTH HISTORY

Patient Name: ____ Date: ________________________

HEALTH MAINTENANCE/SCREENING TESTS:

General: Yearly dental visits? __No __ Yes Date of last dental checkup? __________

Do you take calcium? __ No __Yes Do you take aspirin? __No __Yes

Have you had any of the following tests? Select each box that applies and enter the date and result of the most recent test.

__ Lipid (cholesterol) test Date:__________ Abnormal? __No __ Yes

__ Sigmoidoscopy or Colonoscopy Date:__________ Abnormal? __No __Yes

__ Stool for occult blood (3 samples) Date:__________ Abnormal? __No __ Yes

Men: __PSA (prostate_ Date:__________ Abnormal? __No __ Yes

Woman: __Mammogram Date:__________ Abnormal? __No __Yes

__Clinical breast exam Date:__________ Abnormal? __No __ Yes

__ Pap Smear Date:__________ Abnormal? __No __ Yes

__ Dexa Scan/bone density Date:__________ Abnormal? __No __Yes

Age at start of periods:_____ First day of last menstrual period: ______Age at end of periods:___ Do you have problems with your period or birth control? __No __ Yes

Pregnancies:_____Deliveries:_____ Abortions/miscarriages:____Living children/ages:______________

If post menopause or over age 50, do you take:

Calcium? __No __Yes Estrogen? __No __Yes Progesterone? __No __Yes

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SOCIAL/ECONOMIC: Occupation:____

Highest-year-of-education:____________Marital-status:__Single__Married__Divorced__ Widowed__Other__

Spouse/Partner's name:_____________________ Number of children, ages:_________________________

Who lives at home with you?____

Medication Dose Times/Day

____

____

____

Allergies:____

____

Immunizations: Flu Shot ___ Pneumovax ___ Tetanus ___ TDAP ___ Hepatitis A ____
Hepatitis B ____ MMR ____ Meningitis ____

Signature of person completing this form:____

Reviewed by provider:____

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