YOUR NAME: ______________________ DATE: __________

Family Medicine Center
Adult Initial Visit Information

To help us know all about you and your health, please complete the following before seeing the doctor.

What problem(s) brings you to the doctor today? ______________________

How long have you had it/them? ______________________

Please list below medications you take:

MEDICATION and STRENGTH *Example: Aspirin 325 mg*	NUMBER OF TIMES *Example: every morning*	DOCTOR WHO PRESCRIBED

What medicines are you allergic to? Other allergies?

____

Please circle any of the following that you have ever been told you had:

Diabetes	Hypertension/high blood pressure	Heart Disease	Anemia
Mental health problems	Kidney Disease	Liver disease(s)	Thyroid Disease
Varicose veins	Epilepsy	Hepatitis	Asthma
Arthritis	Stroke	Cancer	Lung disease
Have you ever been in a major accident?			**YES** **NO**
Have you ever had a blood transfusion?			**YES** **NO**

YOUR NAME: ______________________________ DATE: ________________

ANY OTHER HEALTH PROBLEMS NOT LISTED ABOVE (please list):

____

Please list any operations you have ever had:

Have you ever been in the hospital overnight? For what reason(s)?

FOR WOMEN

How many times have you ever been pregnant? __________
How many times have you had a baby? __________
How many living children do you have now? __________

Are you still having menses (periods)? YES NO
Are you using birth control? YES NO
If yes, what kind: ____________________

FOR EVERYONE

Do you have any spiritual beliefs that would help us with your care? YES NO
Do you have a living will or advance directive? YES NO
Do you have a health care power of attorney? YES NO

What is your marital status? MARRIED SINGLE WITH PARTNER
DIVORCED SINGLE WITHOUT PARTNER

Who lives in your household (please list)? ____
____

YOUR NAME: ______________________________ DATE: ________________

Where do you work? ____

What kind of job do you do? ______________________________________

Do you have any concerns about the safety of your job? YES NO

Do any of your co-workers have safety concerns? YES NO

Are you satisfied with your work? YES NO

What is your highest level of education?

SOME HIGH SCHOOL COMPLETED HIGH SCHOOL

COMPLETED COLLEGE POST-COLLEGE EDUCATION

Do you have any hobbies (please list)? ______________________________

Do you drink alcohol? NO YES

Do you smoke cigarettes? NO YES (how much? _________)

Do you take any other drugs? NO YES (which ones: ______________)

FAMILY HISTORY

Have any of your family members had these following diseases:

(Please use the following letters to indicate who had which disease: M=Mother, F=Father, BR=Brother(s), S=Sister(s), MGF=Maternal grandmother, PGF=Paternal grandfather, PGM=Paternal grandmother)

- Diabetes: ______________________________
- High Blood Pressure: ______________________________
- Heart Problems: ______________________________
- Lung Problems: ______________________________
- Kidney Problems: ______________________________
- Thyroid Problems: ______________________________
- Bleeding Problem: ______________________________
- Clotting Problem: ______________________________
- Cancer (and kind): ______________________________

IMMUNIZATIONS

Do you remember if you have ever had any of the following (and, if so, when was the last time you had it?)

Flu shot	**NO**	**YES**	**When:** ____________
Pneumonia vaccination	**NO**	**YES**	**When:** ____________
Tetanus shot	**NO**	**YES**	**When:** ____________
Shingles vaccination	**NO**	**YES**	**When:** ____________

YOUR NAME: ______________________________ DATE: _______________

Please list any other health concerns that you would like us to know about: