Sunrise Family Clinic

Adult History

Name: _____

Date: _____

Main reason for today's visit: _____

Other concerns:

_____

List all MEDICATIONS AND SUPPLEMENTS (eg. vitamins, over the counter medications) or attach list: □ ***None***

NAME and STRENGTH	REASON taken	FREQUENCY taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy: _____ *Please write additional medications on separate sheet or back.*

ALLERGIES: □ None known

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

SPECIALISTS: Other doctors or specialists (eg. orthopedist, eye doctor, dentist, chiropractor): □ None

NAME	SPECIALTY	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please write any additional specialists on another sheet or on the back.

PREVENTION:

Did you receive all your childhood immunizations? □ Yes □ No

Most recent date of:

□ Tetanus shot _____	□ Pneumonia shot _____	□ Shingles shot _____
□ Flu shot _____	□ Colonoscopy _____	□ Bone density test _____
□ Physical exam _____	□ Pap smear _____	□ Mammogram _____
□ Dental visit _____	□ Eye exam _____	

SEXUAL HISTORY:

Current sexual partner is □ female □ male □ none

Current birth control is: _____ □ abstinence

Do you consider yourself □ heterosexual □ homosexual □ bisexual □ other

Number of partners in last year: _____ Most recent STD testing: _____

Females only:

Date of most recent menstrual period: _____ (or □ menopausal or □ hysterectomy)

Age at first menstrual period: _____ Age at last menstrual period: _____

Any trouble with menses? □ No □ Yes (□ heavy □ irregular □ painful □ bleeding between)

Number of pregnancies: _____ term births: _____ preterm births: _____ miscarriages: _____ abortions: _____

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MEDICAL HISTORY: Have you ever had any of the following?

No	Yes		No	Yes		No	Yes	
□	□	ADD/ADHD	□	□	Eating Disorder	□	□	Lung Disease
□	□	Allergies	□	□	Fibromyalgia	□	□	Mental health problem
□	□	Anemia	□	□	GI Problems	□	□	Muscle, Joint, or Bone Problems
□	□	Anxiety Disorder	□	□	Gout	□	□	Neurological problems
□	□	Arthritis	□	□	Head Injury/Concussion	□	□	Inherited/Genetic Disease
□	□	Asthma	□	□	Headaches/Migraines	□	□	Problems with blood
□	□	Atrial fibrillation	□	□	Heart Disease	□	□	Prostate problems
□	□	Birth Defects	□	□	Heart Problems/Murmur	□	□	Pulmonary Embolism
□	□	COPD	□	□	Heart attack	□	□	Reflux/GERD
□	□	Cancer (Type_____)	□	□	Hepatitis	□	□	Seizures/Epilepsy
□	□	Coronary Artery Disease	□	□	High Cholesterol	□	□	Skin Problems
□	□	Depression	□	□	Hypertension	□	□	Sleep apnea
□	□	Developmental Problems	□	□	Hyperthyroidism	□	□	Stroke
□	□	Diabetes	□	□	Hypothyroidism	□	□	Thyroid Problems
□	□	Diverticulitis	□	□	Kidney/Bladder Issues	□	□	Tuberculosis
□	□	Ear or Hearing Problems	□	□	Liver Disease	□	□	Vision or Eye Problems

Specifics of problems: _____

_____

SURGICAL HISTORY:

SURGERY	REASON	YEAR
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please write additional surgeries on separate sheet or back.

FAMILY HISTORY:

RELATION	ALIVE?	AGE	HEALTH ISSUE
Grandmother (maternal)	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Heart attack □ Blood disorder □ _____
Grandfather (maternal)	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Heart attack □ Blood disorder □ _____
Grandmother (paternal)	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Heart attack □ Blood disorder □ _____
Grandfather (paternal)	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Heart attack □ Blood disorder □ _____
Father	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Heart attack □ Blood disorder □ _____
Mother	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Heart attack □ Blood disorder □ _____
Brother/Sister	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Heart attack □ Blood disorder □ _____
Brother/Sister	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Heart attack □ Blood disorder □ _____
Other _____	Yes/No	_____	□ Cancer (Type _____) □ Heart disease □ Diabetes □ Stroke □ Hypertension □ Stroke □ Blood disorder □ _____

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Name: _____

Date: _____

SOCIAL HISTORY:

Occupation: _____ **Employer:** _____ □ Retired

Highest level of education completed: □ Less than 8th Grade □ 8 □ 9 □ 10 □ 11 □ 12 □ Some college
□ Associate's □ Bachelor's □ Post Graduate

Marital status: □ Married □ Single □ Divorced □ Separated □ Widowed □ Domestic Partner

Exercise level: □ None □ Occasional □ Moderate □ Heavy

Diet: □ Regular □ Vegetarian □ Vegan □ Gluten free □ Low Carb □ Cardiac □ Diabetic □ Other _____

Stress level: □ Low □ Medium □ High

Smoking status: □ Current smoker (amt _____) □ Former smoker (quit date _____) □ Never smoker

Chewing tobacco use: □ Current use (amt _____) □ Former use (quit date _____) □ Never

Alcohol use: □ Heavy (amt _____) □ Moderate (amt _____) □ Occasional □ Never

Marijuana and other drug use: □ Never used □ Current use (drug(s): _____ □ daily □ weekly □ rarely)
□ Former use (drug(s): _____ quit date: _____)

Do you have an advance directive or living will? □ No □ Yes (if yes, please bring a copy for your chart)

Are you able to care for yourself independently? □ Yes □ No

If no, who helps care for you? _____

Caffeine intake: □ None □ Occasional □ Moderate □ Heavy

Home situation (please indicate all in household): □ Spouse/partner □ Children (ages: _____)
□ I live alone □ Mother □ Father □ Roommate □ Other _____

Total number of children (at home or elsewhere): _____

Hobbies/Activities you enjoy: _____

Would you like to talk about any of the following?

□ Feeling sad or anxious □ Help with drugs or alcohol □ Diet and exercise □ Healthy weight loss
□ Quitting smoking □ Issues with sexual health □ Anger management □ Advanced directive

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Have you *recently* had any of the following (circle or underline all that apply)?

Constitutional

fever , night sweats , weight gain (___lbs) , weight loss (___ lbs) , exercise intolerance

Eyes

dry eyes , irritation , vision change

ENMT

difficulty hearing , ear pain

frequent nosebleeds , nose/sinus problems

sore throat , bleeding gums , snoring , dry mouth , oral abnormalities , mouth ulcer , teeth abnormalities , mouth breathing

Cardiovascular

chest pain with activity, arm pain with activity, shortness of breath when walking , shortness of breath when lying down , palpitations , known heart murmur , light-headed on standing

Respiratory

cough , wheezing , shortness of breath , coughing up blood , sleep apnea

Gastrointestinal

abdominal pain , vomiting , change in appetite , black or tarry stools , frequent diarrhea , vomiting blood , dyspepsia , reflux

Genitourinary

urinary loss of control , difficulty urinating , increased urinary frequency , hematuria , incomplete emptying

Musculoskeletal

muscle aches , muscle weakness , joint pain (location_____), back pain , swelling in the extremities

Integumentary

abnormal mole , jaundice , rash , itching , dry skin , growths/lesions

Neurologic

loss of consciousness , weakness , numbness , seizures , dizziness , frequent or severe headaches , migraines , restless legs

Psychiatric

depression , anxiety , sleep disturbances , restless sleep , feeling unsafe in relationship , alcohol abuse

Endocrine

fatigue , increased thirst , hair loss , increased hair growth , cold intolerance

Hematologic/Lymphatic

swollen glands , easy bruising , excessive bleeding

Allergic/Immunologic

runny nose , sinus pressure , itching , hives , frequent sneezing

Other: Please list

□ None of the above