

Carpenter Primary Healthcare

Initial Adult History Questionnaire

Today's Date: _____ Patient Name: _____ DOB: _____

How did you hear about our office? _____

Please list any specialists you are currently seeing: _____

Reason for today's visit: _____

Do you have a medical advance directive or a living will? Yes No (If yes, please provide our office with a copy.)

Do you need any of the following: (Please circle)

Disability Paperwork Return to work note Surgical Clearance Prescription Refills Beside Commode Rolling Walker Cane

Are you interested in any of the following? (Please Circle)

Weight Loss HIV screening Diabetes screening Preventing pregnancy STD screening Cervical Cancer Vaccine Shingles Vaccine

Past Medical History

Abnormal Heart Rhythm	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Lqlpv'Rclp"*ur gekh{ -aaaaaaaaaaaaa	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Cuj o c	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Mkf pg{ 'F kugcug	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Dcem'Rclp	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Nkxgt 'F kugcug	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Dkr qrt 'F kuqtf gt	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Nwr wu	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Ecpegt "Ur gekh{ <aaaaaaaaaaaaaaa	<input type="checkbox"/> Currently <input type="checkbox"/> Past	P gwtqr c j {	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Eqpi gukxg'J gctv'Hckwng	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Ucteqlf quku	<input type="checkbox"/> Currently <input type="checkbox"/> Past
F gr tguukqp	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Uqo cej "Wregtu	<input type="checkbox"/> Currently <input type="checkbox"/> Past
F kcdgvgu	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Utqng	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Go r j { ugo c	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Qvj gt <aaaaaaaaaaaaaaaaaaaaa	<input type="checkbox"/> Currently <input type="checkbox"/> Past
Hkdtqo { cri kc	<input type="checkbox"/> Currently <input type="checkbox"/> Past	Qvj gt <aaaaaaaaaaaaaaaaaaaaa	<input type="checkbox"/> Currently <input type="checkbox"/> Past
J gctv'Cwcnlqt'dmqnci gu	<input type="checkbox"/> Currently <input type="checkbox"/> Past		
J ki j "Dmqf "Rtguuwg	<input type="checkbox"/> Currently <input type="checkbox"/> Past		
J ki j "Ej qrguxqn	<input type="checkbox"/> Currently <input type="checkbox"/> Past		
HIV	<input type="checkbox"/> Currently <input type="checkbox"/> Past		

Family History

Please use the following key: MGM- Maternal Grandmother, PGM- Paternal Grandmother, MGF- Maternal Grandfather, PGF- Paternal Grandfather, M-Mother, F-Father, A- Aunt , U- Uncle, B-Brother, S- Sister, C- Cousin

Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Dialysis for Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Cancer, (Type): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Additional Family History: _____			

Social History

What is your occupation? _____

Do you have a significant other? Yes No Marital Status: _____

Do you have any children? Yes No If yes, how many? _____

Have you ever used tobacco? Currently Formerly Occasionally Never

If yes: Packs per day _____ How many years? _____

Do you drink alcohol? Currently Formerly Occasionally Never

If yes, what do you drink? _____ How much? _____ How often? _____

Have you ever done drugs? Currently Formerly Occasionally Never

If yes, please specify drug and length of use: _____

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Reproductive History (Women Only)

Do you have regular monthly periods? Yes No
 Number of days in cycle? _____
 Heavy Bleeding? Yes No Painful? Yes No
 What age did you start having periods? _____
 What age did you stop having periods? _____ Reason: _____
 Have you ever been pregnant? Yes No Number of pregnancies? _____ Complications? _____

Past Surgical History

Please check any surgeries you have had:

<input type="checkbox"/> Amputation , Please specify: _____	Date: _____
<input type="checkbox"/> Appendix Removed	Date: _____
<input type="checkbox"/> Back Surgery Please specify: _____	Date: _____
<input type="checkbox"/> Gallbladder Removed	Date: _____
<input type="checkbox"/> Heart Bypass/ Stent	Date: _____
<input type="checkbox"/> Hysterectomy - <input type="checkbox"/> Partial or <input type="checkbox"/> Total Reason? _____	Date: _____
<input type="checkbox"/> Mastectomy	Date: _____
<input type="checkbox"/> Tonsillectomy	Date: _____

Please list and other surgeries with details:

Medication

Name of Medication	Dose	Number of times per day	Name of Medication	Dose	Number of times per day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medication Allergies- Please list name of medication and type of reaction: _____

Other Allergies- Please list name and type of reaction: _____

Preventative Care

Name of test	Date done	Results	Ordering Doctor
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Prostate Blood Test	_____	_____	_____
Stool Cards	_____	_____	_____
Colonoscopy	_____	_____	_____
Pneumonia Vaccine	_____	_____	_____
Tetanus Vaccine	_____	_____	_____