Name:________________________ Day Phone # (____) _____-_______
Date Of Birth ____/____/____ Home Phone # (____) _____-_______
E-mail Address ____

Today's Date: ____________________

Pharmacy: ______________________

ADC Family Practice New Adult Patient/Annual Form

MRN:

Reason For Your Visit ____

CURRENT PROBLEMS:
Which of the following additional symptoms are you currently having?

Symptom	☐	Symptom	☐	Symptom	☐
Back pain		Fatigue		Night sweats	
Bladder leakage		Feelings of depression		Painful periods	
Blood in your urine		Fever		Persistent cough	
Bloody or black stools		Frequent regurgitation		Sexual difficulty	
Breast discharge		Frequent indigestion		Shortness of breath	
Breast lumps		Frequent urination		Skin Disorder	
Chest pains		Hard to empty bladder		Sleeping problems	
Chronic constipation		Headache		Sores on penis/vagina	
Chronic diarrhea		Heart palpitation		Temporary loss of speech	
Cold Intolerance		Heat intolerance		Temporary loss of strength	
Coughing blood		Joint pains		Vaginal discharge	
Difficulty hearing		Menstrual Problems		Vision changes	
Easy bruising/bleeding		Mole changes		Weight Gain	
Excessive sweating		Nasal congestion		Wheezing	
Fainting /blackout		Nervousness/anxiety		Other:	

PAST MEDICAL HISTORY:
Please review the below list, and check any problems that you have had now or in the past:

Condition	☐	Condition	☐	Condition	☐
Abnormal Pap Smear		Drug Abuse		Osteoarthritis	
Acne		Emphysema		Osteopenia	
Adult ADD		Eczema		Osteoporosis	
Alcohol abuse		Frequent Urinary Tract Infections		Positive TB skin test	
Anemia		Frequent Sinus Infections		Prostate problems	
Anorexia		Gallstones		Psoriasis	
Anxiety disorder		Gout		Reflux (heartburn)	
Asthma		Glaucoma		Rheumatoid Arthritis	
Atrial Fibrillation		Heart Attack		Rosacea	
Bipolar disorder		Heart Disease		Seasonal Allergies	
Blood clot		Hepatitis		Seizures	
Blood Transfusion		High Blood Pressure		Sexually transmitted disease:	
Breast Cancer		High cholesterol		Which One:	
Chronic Bronchitis		Irritable Bowel Syndrome		Stroke	
Crohn's disease		Kidney Stones		Tuberculosis	
Colon Polyps		Kidney disease		Thyroid disease/cancer	
Congestive Heart Failure		Kidney Infections		Stomach Ulcers	
Depression		Lupus		Ulcerative Colitis	
Diabetes		Melanoma or other skin Cancer		Valve problem/murmur	
Diverticulosis		Migraines		Warts	

Other medical problems not in list:____

Have you had **surgery** in the past**?** ☐**Yes** ☐**No** If yes, please check or list**:**

	Type of surgery:	Year:
	Appendectomy	
	Arthroscopy (Joint)	
	Back surgery	
	Bypass Surgery (Heart)	
	Cataract Surgery	
	Cesarean section	
	Gallbladder removal	
	Hemorrhoids	
	Hernia	
	Hip Replacement	

	Type of surgery:	Year:
	Hysterectomy	
	Knee Replacement	
	LEEP /LOOP(Cervix)	
	Mastectomy/lumpectomy	
	Neck surgery	
	Polyp removal (colon)	
	Tonsillectomy	
	Vasectomy/Tubal Ligation	
	Plastic surgery:	
	Other:	

Have you ever been hospitalized? ☐**Yes** ☐**No** For what? ___________________________________

Current Medications: (please include over the counter medications and food supplements)

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are You Allergic to any medications? ☐**Yes** ☐**No**

Drug Name:	Type of Reaction:

Family History: (grandparents, siblings, parents, aunts, uncles, children)

Have any of your **family members** had any of the following problems?

	Condition:	Family Member & age of onset:
	Heart Disease/Attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid disease	
	Depression	
	Other Mental Illness:	
	Alcoholism	
	Asthma	

	Condition:	Family Member & age of onset:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer:	

Any other illness in the family not listed: ____

Has anyone in your immediate family died before the age of 50? ☐**Yes** ☐**No**

If yes, explain:____

Social History:

Occupation: ____

Marital Status (circle one): **Single Divorced Separated Married Widowed**

Do you have any **children**? ☐**Yes** ☐**No** Please list names and ages: ___________________________________
____

Who lives with you ? ____

Health Habits:

1. Do you **exercise**? ☐**Yes** ☐**No** If so, what type and how often? ___________________
2. Do you **smoke** currently? ☐**Yes** ☐**No** If so, how much? _____________ How long? ____________
3. Did you **smoke** in the past? ☐**Yes** ☐**No** How many years?____How much? _____ Quit date___/____/____
4. Are you **exposed** to smoke? ☐**Yes** ☐**No**
5. Any other **tobacco** use? ☐**Yes** ☐**No** Type: **Cigars chewing tobacco snuff Other:** _____________
6. Do you drink **caffeine**? ☐**Yes** ☐**No** If so, how much? _______________________________
7. Have you ever used **street drugs**? ☐**Yes** ☐**No**
Which ones? **IV drugs amphetamines cocaine heroin marijuana downers inhalants**
Other:____
Are you still using? ☐**Yes** ☐**No** Which one(s)? _________________________________
8. Do you drink **Alcohol** ? ☐**Yes** ☐**No** What kind? **Beer wine liquor Other:** ____________
If so, How often?____
How many at one time? ____
Have you ever had a problem with alcohol in the past? _____________________________
9. Are you **sexually active** (in the last year)? ☐**Yes** ☐**No**
If yes, please circle all that apply: **1 partner multiple partners Male partner(s) Female partner(s)**
10. Are you currently using **birth control**? ☐**Yes** ☐**No** Which one? **Condoms The Pill Vasectomy/tubal other:**
11. How many servings of **Milk or Dairy** do you eat per day? _______
Do you take a **calcium supplement**? ☐**Yes** ☐**No**
12. Do you eat out at **restaurants** regularly? ☐**Yes** ☐**No** Times per week: 0 <1 1 2 3 4 5 >5
13. Do you wear **sunscreen**? ☐**Yes** ☐**No**
14. Have you had your **eye exam** this year? ☐**Yes** ☐**No**
15. Have you had your **dental exam** this year? ☐**Yes** ☐**No**
16. Do you wear your **seat belt** every time you drive? ☐**Yes** ☐**No**
17. Do you have a **living will**? ☐**Yes** ☐**No**
18. Is there concern for your **safety**? (emotional, physical, or sexual abuse) ☐**Yes** ☐**No**

Health Maintenance:

Have you ever had the following:
Cholesterol screening? ☐**Yes** ☐**No** Results: ____________________
Sexually transmitted disease screening? ☐**Yes** ☐**No** Results:__________________________
Tetanus shot? ☐**Yes** ☐**No** What year? _________________________
Colon Cancer screen? ☐**Yes** ☐**No** (colonoscopy, flexible sigmoidoscopy)
What year? _________ Results? ____
Flu shot? ☐**Yes** ☐**No** When? _____________________________
Pneumonia Vaccine? ☐**Yes** ☐**No** When? _____________________________

For Women:
*****What was the date of your last menstrual period? ___/____/____**
How many **pregnancies** have you had? ______ **births**? ______**miscarragies**?______**abortions**? ________
Pap Smear? ☐**Yes** ☐**No** Date: ___/____/____ Results: ____________
Mammogram? ☐**Yes** ☐**No** Date: ___/____/____ Results: ____________
Bone Density? ☐**Yes** ☐**No** Date: ___/____/____ Results: ____________