

## Adult Initial Visit History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Date of Last Physical: \_\_\_\_\_  
Referred by (physician or other): \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Members Living in Household (names, ages): \_\_\_\_\_  
\_\_\_\_\_  
Drug Allergies: \_\_\_\_\_

### HABITS

Tobacco Use: Smoking: Yes  Packs per day \_\_\_\_\_ No  Quit (date) \_\_\_\_\_  
Chewing Tobacco Yes  Amount \_\_\_\_\_ No  Quit (date) \_\_\_\_\_  
Other: Yes  Amount \_\_\_\_\_  
Alcohol: Yes  No  Quit \_\_\_\_\_ (date) oz. per day \_\_\_\_\_  
How many alcoholic beverages do you drink during in one week? \_\_\_\_\_  
Recreational Drugs (i.e. marijuana, cocaine, etc.) Yes  No   
Type: \_\_\_\_\_ How often: \_\_\_\_\_  
Caffeine drinks (i.e. coffee, cola, tea) amount per day: \_\_\_\_\_  
Exercise (type and frequency): \_\_\_\_\_

### PRESCRIBED MEDICATIONS

(including oral contraceptives):

**Name/Dose/Frequency (how many times daily)**

**Name/Dose/Frequency (how many times daily)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### OVER-THE-COUNTER MEDICATIONS

**Name/Dose/Frequency (how many times daily)**

**Name/Dose/Frequency (how many times daily)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FEMALES

Age of first menses: \_\_\_\_\_ Duration of menstrual cycle (no. of days): \_\_\_\_\_  
No. of pregnancies: \_\_\_\_\_ No. of abortions: \_\_\_\_\_ No. of miscarriages \_\_\_\_\_  
Date of last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

**IMMUNIZATIONS**

Date of last tetanus: \_\_\_\_\_ influenza: \_\_\_\_\_ pneumovax(pneumonia): \_\_\_\_\_

**PAST MEDICAL HISTORY**

Hospitalizations:(include date &amp; reason): \_\_\_\_\_

Operations: (include date &amp; reason): \_\_\_\_\_

**PRESENT MEDICAL PROBLEMS**

(i.e. hypertension, diabetes, etc.)

Problem:

Date of Onset:

**FAMILY HISTORY****Check conditions and relationship of any blood relatives**

	<b>Self</b>	<b>Father</b>	<b>Father's Parents</b>	<b>Mother</b>	<b>Mother's Parents</b>	<b>Sister</b>	<b>Brother</b>	<b>Children</b>
Alcoholism								
Allergies								
Anemia								
Arthritis								
Asthma								
Birth Defects								
Bleeding Problems								
*Cancer								
Diabetes								
Epilepsy								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Migraine Headaches								
Mental Disorders								
Suicide								
Tuberculosis								
Ulcers								
Other								
List type(s) of cancer								

If Deceased, Relationship: \_\_\_\_\_ Cause of Death: \_\_\_\_\_