Adult Initial Visit History

Today's Date:_____
Name:_____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 & reason):_____
_____
_____

Operations: (include date & reason):_____
_____
_____

PRESENT MEDICAL PROBLEMS (i.e. hypertension, diabetes, etc.)

Problem: Date of Onset**:**
_____
_____
_____
_____
_____

FAMILY HISTORY

Check conditions and relationship of any blood relatives

	Self	**Father**	**Father's Parents**	**Mother**	**Mother's Parents**	**Sister**	**Brother**	**Children**
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:_____