INTEGRATIVE FAMILY MEDICINE
WHOLE HEALTH FOR THE WHOLE FAMILY

# New Patient Adult History Form

| Name: | Gender: M / F | Today's Date: |
|---|---|---|
| Date of Birth: | Age: | |

| **What is your main health concern(s) and reason for your visit today?** |
|---|
| 1. |
| 2. |
| 3. |
| Other: |

| **Past Medical History-Do you have any of the following:** | | |
|---|---|---|
| Diabetes ☐ Yes ☐ No Comments: | Arthritis ☐ Yes ☐ No Comments: | Varicose Veins ☐ Yes ☐ No Comments: |
| High Blood Pressure ☐ Yes ☐ No Comments: | Back/Neck Problems ☐ Yes ☐ No Comments: | Gallbladder ☐ Yes ☐ No Comments: |
| Heart Attack/Disease ☐ Yes ☐ No Comments: | Epilepsy/ Neurological problems ☐ Yes ☐ No Comments: | Hepatitis/Liver ☐ Yes ☐ No Comments: |
| High Cholesterol ☐ Yes ☐ No Comments: | Osteoporosis ☐ Yes ☐ No Comments: | Pacemaker ☐ Yes ☐ No Comments: |
| Irritable Bowel Syndrome ☐ Yes ☐ No Comments: | Fractures ☐ Yes ☐ No Comments: | Joint Problems ☐ Yes ☐ No Comments: |
| Anorexia ☐ Yes ☐ No Comments: | Incontinence ☐ Yes ☐ No Comments: | Cancer ☐ Yes ☐ No Comments: |
| Asthma ☐ Yes ☐ No Comments: | Kidney Disease ☐ Yes ☐ No Comments: | Depression/Anxiety ☐ Yes ☐ No Comments: |
| Emphysema ☐ Yes ☐ No Comments: | Thyroid Dysfunction ☐ Yes ☐ No Comments: | Psychiatric Disorders ☐ Yes ☐ No Comments: |
| Obesity ☐ Yes ☐ No Comments: | Tuberculosis ☐ Yes ☐ No Comments: | Alcoholism ☐ Yes ☐ No Comments: |
| Allergies ☐ Yes ☐ No Comments: | Stroke ☐ Yes ☐ No Comments: | Insomnia ☐ Yes ☐ No Comments: |
| Aneurysm ☐ Yes ☐ No Comments: | Blood Clots Leg/Lung ☐ Yes ☐ No Comments: | Other ☐ Yes ☐ No Comments: |

| **Sexual History** | |
|---|---|
| ***Females:*** Are you Pregnant? ☐ Yes ☐ No ☐ Unsure | Last Bone Density: ☐ Normal ☐ Abnormal |
| Last menstrual period: | Last Colonoscopy: ☐ Normal ☐ Abnormal |
| Length of period (days): | Hormone Replacement Therapy: |
| Number of days between periods: | Birth Control Method: |
| Age of 1st period: | Prolapse Bladder/Rectum/Uterus: ☐ Yes ☐ No |
| Cramps: ☐ Yes ☐ No Mild / Moderate / Severe | How many Pregnancies:_____ Deliveries: _____ Abortions: _____ Miscarriages:_____ |
| Are you breast feeding? ☐ Yes ☐ No | Sexually Active: ☐ Yes ☐ No # of current partners?_____ |
| Age of Menopause: | Your Partner is: ☐ Male ☐ Female ☐ Both |
| Abnormal Vaginal Bleeding: ☐ Yes ☐ No | STDs: ☐ Herpes ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis |
| Last Pap: ☐ Normal ☐ Abnormal | Infections: ☐ Yeast ☐ Bacterial Vaginosis ☐ PID ☐ Discharge |
| Last Mammogram: ☐ Normal ☐ Abnormal | Other: |
| | |
| **Males:** | |
| Last Prostate Exam: | Penile Discharge or pain: ☐ Yes ☐ No Comments: |
| Last Colonoscopy: | Sexually Active: ☐ Yes ☐ No # of current partners?_____ |
| Last PSA: | Your partner is: ☐ Male ☐ Female ☐ Both |
| Vasectomy: ☐ Yes ☐ No Comments: | STDs: ☐ Herpes ☐Gonorrhea ☐Chlamydia ☐HPV ☐Syphilis |
| Erectile Dysfunction: ☐ Yes ☐ No Comments: | Other: |
| Testicular Lumps: ☐ Yes ☐ No Comments: | |

| **Past Surgical History/Hospitalizations** *(please provide reason/year)* | | |
|---|---|---|
| Surgery Procedure: | Year: | Reason: |
| | | |
| | | |
| | | |

| **Medications:** *(Prescription and non-prescription medicines, supplements, home remedies, birth control pills)* | | | | | |
|---|---|---|---|---|---|
| Medication: | Dose: | Times per day | Medication: | Dose: | Times per day |
| 1. | | | 7. | | |
| 2. | | | 8. | | |
| 3. | | | 9. | | |
| 4. | | | 10. | | |
| 5. | | | 11. | | |
| 6. | | | 12. | | |

| **Allergies and Reactions to Medicine/Foods/Other Agents:** | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

| **Social History:** | | |
|---|---|---|
| Occupation: | Marital Status: □ Single □ Married<br>□ Divorced □ Widowed | Social Drug Use: □ Yes □ No<br>Type: Amount:<br>How often: |
| Cigarettes/Tobacco use: □ Yes □ No<br>Pack/Day:<br>For how long:<br>Quit date: | Alcohol use: □ Yes □ No<br>Type: Amount:<br>How often: | Abuse/Domestic Violence:<br>□ Yes □ No<br>Past or Present Relationship |
| Advance Directives: □ Yes □ No | Do you feel safe in your current relationship? □ Yes □ No | |

**Nutrition and Diet:**

How do you best describe your diet? *(may select more than one)*

□ Healthy □ Moderately Healthy □ Poor □ Majority Take-Out Meals □ Majority Home-Cook Meals □ Other_____

Your diet is best defined as: □ Regular □ Vegetarian □ Vegan □ Other_____

How many meals do you usually eat daily? _____

Why types of food do you regularly snack on?_____

Do you consider your weight appropriate? □ Yes □ No Comments:

What diets or prescriptions have you tried for weight loss in the past?_____
Was this diet or prescription successful? □ Yes □ No Comments:

What is the most you have ever weighed as an adult?_____

Do you drink coffee? □ Yes □ No How often?_____

Do you drink tea? □ Yes □ No How many cups/day?_____

Do you drink Sodas? □ Yes □ No How many cups/day?_____

## Mental Health History:

| | |
|---|---|
| Do you think you are under a lot of stress? □ Yes □ No<br>How often? □ Now □ Often □ Always | How do you handle your stress? _____<br>_____ |
| If yes, What is your major source of stress?<br>_____ | What do you do to relax?<br>_____ |
| How many hours of sleep do you get at night?<br>_____ | Do you take sleeping aids to help you sleep at night? □ Yes □ No<br>If yes, how often and what type?_____ |
| Do you feel you regularly get enough sleep?<br>□ Yes □ No | Do you have nervous habits? □ Yes □ No<br>Comments:_____ |

## Exercise:

| | |
|---|---|
| What types of exercise do you regularly do?<br>□ Aerobics □ Running □ Weight Training<br>□ Yoga □ Stair Climbing □ Hiking □ Walking<br>□ Swimming □ Rowing □ Pilates □ Other | Do you exercise regularly (2-3 times) weekly?<br>□ Yes □ No<br>If yes, how long? _____ min/hrs per session |
| Do you stretch before and/or after exercise? □ Yes □ No | Do you have pain or discomfort with exercise/stretching?<br>□ Yes □ No If so, where? |

## Travel:

Have you ever traveled outside the continental U.S.?

□ Yes □ No If so, when and where?_____
_____

Did you ever become ill while traveling outside the U.S. ?

□ Yes □ No If so, when?_____
_____

## Family History:

Have any members of your family had the following?

Alcoholism □ Yes □ No
Arthritis □ Yes □ No
Alzheimer's Disease □ Yes □ No
Bleeding disorders □ Yes □ No
Diabetes □ Yes □ No
Epilepsy □ Yes □ No
Are your parents living? □ Yes □ No

Heart disease □ Yes □ No
High blood □ Yes □ No
Intestinal/Colon □ Yes □ No
Kidney disease □ Yes □ No
Mental Illness □ Yes □ No
Migraine □ Yes □ No
If No, which parent deceased and why?_____

Stroke □ Yes □ No
Thyroid Disease □ Yes □ No
Gastro Ulcers □ Yes □ No
Obesity □ Yes □ No
Other:

## Immunization History: *Please provide dates of vaccines and have immunization record available*

| | | | |
|---|---|---|---|
| Tdap/DT: | Varicella: | TB Test: | Flu |
| Hep A: | Pneumococcal: | MMR: | Shingles: |
| Hep B: | Flu: | Meningococcal: | Other: |

## Review of Systems: *(check all that apply)*

Constitutional: □ Weight Loss or gain □ Fever or chills □ Fatigue □ Trouble Sleeping □ Other

Head/Neck: □ Pain/Headaches □ Lumps □ Blurry Vision □ Swollen glands □ Stiffness □ Decreased Hearing □ Other

Breast: □ Lumps □ Discharge □ Breast-feeding □ Pain □ Self-Exams □ Other

Cardiovascular: □ Rapid Heart rate □ Irregular Heart Beat □ Chest pain □ Shortness of breath □ Other

Respiratory: □ Cough □ Difficulty breathing □ Wheezing □ Painful breathing □ Other

Musculoskeletal: □ Muscle or joint pain □ Stiffness □ Back pain □ Swelling of Joints □ Muscle cramps □ Other

Abdomen/Gastro:□ Pain □ Bloating □ Blood in stool □ Poor appetite □ Diarrhea □ Constipation □ Nausea □ Other

Urinary: □ Frequency □ Urgency □ Burning or pain □ Blood in urine □ Incontinence □ Other

Neurological: □ Dizziness □ Headaches □ Fainting □ Seizures □ Numbness/Tingling □ Weakness □Other

Psychiatric: □ Insomnia □ Depression □ Anxiety □ Mood Swings □ Memory Loss □ Nervousness □ Other

Skin: □ Rashes □ Itching □ Dryness □ Color Changes □ Lumps □ Hair and nail changes □ Other

Other:

**Please use this space below for any additional Information:** _____