Patient Name: _____ Sex: _____ Gender: _____ Date of Birth: _____

Marital Status: _____ Occupation: _____

MY LAST EXAM WAS	
	Date
Date of last Mammogram	
Date of last Pap Smear	
Date of last Menstrual Period	

HOSPITALIZATIONS / SURGERIES / DIAGNOSTIC TEST			
Hospitalization / Surgery / Diagnostic Test	Date	Hospitalization / Surgery / Diagnostic Test	Date

IMMUNIZATIONS	
Are you currently updated on all immunizations? Please circle one: Yes No Unsure	
	Date: If You Remember
Last Influenza	
Last Pneumonia	
Last TB Skin Test	
Last Tetanus	

ALLERGIES OR REACTIONS ❑ None		
Substance	Year of Reaction	What Happened

LIST ANY PRESCRIPTION, HERBAL OR OVER-THE-COUNTER MEDICATIONS YOU TAKE AND DOSES YOU ARE USING		
Drug	How Often	What For

DTM0169

Place Patient Label Here

Epic: ENC level to Patient Intake - Scan
Description: Adult Health Hx
Form M5001 (Rev. 07/2020)

SOCIAL HISTORY			
Tobacco ❑ Yes ❑ No	Packs or Cans Per Day _____	For How Long? _____	Date Quit _____
Alcoholic Beverages Amount_____	Frequency_____	Cups of Coffee per Day _____	Pop or Tea per Day _____
Have you used street drugs? ❑ Yes ❑ No	Have you used IV drugs? ❑ Yes ❑ No		
Total # of children in home _____	# of abortions _____	# of miscarriages _____	# of premature births _____
# of living children: _____	# of full-term babies: _____		
How many vaginal births have you had: _____	How many cesarean births have you had: _____		
Any complications of pregnancy:			
Are you afraid of anyone at home? ❑ Yes ❑ No			

MENSTRUAL HISTORY		
Age periods began: Duration:	# of days bleeding:	Age periods stopped:
Spacing of periods:	Amount of flow: Light Moderate Heavy	

SEXUAL HISTORY ❑ Abstinence					
My sexual preference is:	Male	Female	Prior Venereal Disease	Yes	No
My current partner is:	Male	Female	Multiple sexual partners	Yes	No

FAMILY HISTORY				
Has any Blood Relative ever had the following:	Yes	No	Relationship	Age at Onset
Cancer				
Glaucoma				
Tuberculosis				
Diabetes				
Heart Trouble				
High Blood Pressure				
Stroke				
Epilepsy				
Emotional/Mental Problems				
Suicide				
Birth Defects				
Other				
Other				

	IF CURRENTLY LIVING		IF CURRENTLY DECEASED	
	Age	Current Health Status	Age at Death	Cause of Death
Father				
Mother				
Siblings				

We believe that your family and emotional health is an important part of your physical health. Please answer these questions honestly so your doctor can provide the best possible medical care for you and your family.

1. Please check if you have recently experienced any of the following (✓):

❑ Feeling sad or irritable most of the time
❑ Sleep too much or too little
❑ Feel tired a lot
❑ Sexual problems
❑ Eat too much or too little, gained or lost weight
❑ Feel hopeless, helpless, worthless
❑ Thought about or attempted hurting yourself
❑ Anxiety or panic attacks
❑ Difficulty relaxing
❑ Feel worried
❑ Nightmares or flashbacks
❑ Memory problems, confusion
❑ Mood swings
❑ Fears, phobias
❑ Headaches (tension or migraines)
❑ So irritable or frustrated you start fights
❑ So excited you didn't sleep
❑ Eating Disorder (dieting, binging, vomiting)
❑ Chronic pain, low back pain, pelvic, or stomach pain
❑ High blood pressure, asthma, diabetes
❑ Believe you have serious illness or many illnesses
❑ Injury causing unconsciousness
❑ Seems like people are talking about you
❑ Seems like people want to hurt you
❑ Seeing or hearing things
❑ Difficulty with thinking clearly, concentrating or making decisions
❑ Feeling especially important or having special powers
❑ Marriage/relationship conflicts
❑ Family conflicts
❑ Physically, mentally or sexually abused
❑ Someone in family has emotional problems
❑ Child behavior problems
❑ Aging parents or family members
❑ Grieving
❑ Cultural/social adjustment
❑ Recent move
❑ Financial stress
❑ Facing criminal charges or legal procedure
❑ Job or employer-related stress
❑ Concerns with alcohol use
❑ Drug Use
❑ Tobacco Use
❑ Other _____

2. How would you describe relationships in your family? Do you have caring friends?
❑ Bad ❑ Poor ❑ Fair ❑ Good ❑ Excellent ❑ Yes ❑ No

3. How much pressure or stress is there in your life? None 1 2 3 4 5 A lot
How many changes were there in your life in the past year? None 1 2 3 4 5 A lot
How able are you to handle the stress in your life: Well 1 2 3 4 5 Not Well
Do you think that stress is affecting your health? ❑ Yes ❑ No If yes, how? _____

4. In the last three months:

Have you felt you should cut down or stop drinking:	❑ No	❑ Sometimes	❑ Quite often	❑ Very Often
Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking?	❑ No	❑ Sometimes	❑ Quite often	❑ Very Often
Have you felt guilty or bad about how much you drink?	❑ No	❑ Sometimes	❑ Quite often	❑ Very Often
Have you been waking up wanting to have an alcoholic drink?	❑ No	❑ Sometimes	❑ Quite often	❑ Very Often
If you take pain or nerve pills, how often do you run short?	❑ Never	❑ Sometimes	❑ Quite often	❑ Very Often

Have any family members had problems with drugs or alcohol? ❑ Yes ❑ No
Have you ever been treated for problems with drugs and/or alcohol? ❑ Yes ❑ No

5. What do you find most satisfying about your life or yourself? _____

6. What do you find most worrisome about your life or yourself right now? _____

7. Have you ever thought about or attempted to hurt yourself? ❑ Yes ❑ No

8. Are you currently in counseling? ❑ Yes ❑ No Have you had counseling in the past? ❑ Yes ❑ No
Are you interested in getting counseling for any current problems or growing concerns? ❑ Yes ❑ No

9. Do you ever feel afraid of or threatened by your spouse, partner, or someone else who is important or close to you? ❑ Yes ❑ No

10. Within the last year, have you been hit, slapped, choked, kicked, forced to have sex or otherwise hurt by someone? ❑ Yes ❑ No If yes, who hurt you? _____

Place Patient Label Here

REVIEW OF SYSTEMS: (Y) yes (N) no (O) occasionally

CONSTITUTIONAL	Y	N	O
Fatigue			
Fever			
Chills			
Sweats			
Night Sweats			
Weight Change			
Diabetes or high blood sugar			
Anemia			
EYES			
Glaucoma			
Cataracts			
Corrective eyeglasses or lenses			
Recent visual change			
Date of last exam: _____			
ENT			
Allergic Rhinitis			
Frequent sore throats			
Recent hearing change			
Hearing aids			
Ringing in your ears			
Dentures			
Sores in mouth			
Frequent nose bleeds			
Persistent hoarseness			
Difficulty swallowing			
Frequent nasal congestion			
Weakness in arm or leg			
Frequent dizziness			
SKIN			
Skin lesions or change in moles			
Skin Rash			
NEUROLOGIC			
History of seizures			
History of fainting (syncope)			
History of temporary paralysis			
History of stroke (CVA)			
Frequent headaches			
ALLERGIC/IMMUNOLOGICAL			
History of hives			
Frequent pneumonia			
Removal of spleen			
Use of Prednisone or steroids			

CARDIOVASCULAR	Y	N	O
High blood pressure			
Rheumatic fever			
Chest tightness, pressure or pain			
Swelling in your legs or feet			
Sleep on more than one pillow			
Awaken at night unable to get your breath			
Pounding heart beats (Palpitations)			
Rapid heart rates for no reason			
Light headedness			
History of heart murmur			
Leg cramps when walking			
Heart attack			
GASTROINTESTINAL	**Y**	**N**	**O**
Frequent heartburn or indigestion			
Frequent nausea			
Frequent or recurrent vomiting			
Vomiting blood			
Frequent or recurrent diarrhea			
Constipation			
Hemorrhoids			
Blood in stool			
Black stools			
Use laxatives frequently			
Ulcers			
Date of last exam: _____			
GENITOURINARY	**Y**	**N**	**O**
Get out of bed at night to urinate			
If yes how many times _____			
History of kidney stones			
Blood in urine			
Painful urination			
PSYCHIATRIC	**Y**	**N**	**O**
Depression			
Anxiety			
Crying Spells			
Change in personality			
LUNGS	**Y**	**N**	**O**
Severe shortness of breath			
Asthma or emphysema			
Coughing up blood			
Tuberculosis			
Frequent Cough			
Other: _____			

MEN ONLY	Y	N	O
Difficulty with erection			
Dribbling of urine			
Decreased urine stream size			
Difficulty starting urination			
Prostate problems			
Discharge from the penis			
Lump in testicles			
WOMEN ONLY	**Y**	**N**	**O**
History of breast lumps or Breast tissue changes			
Nipple discharge			
Change in periods			
Hot flashes			
Hormonal medications			
Irregular periods			
Severe cramps with periods			
Abnormal vaginal bleeding or spotting (not with periods)			
Abnormal pap test			
RESPIRATORY	**Y**	**N**	**O**
Frequent cough			
Cough up sputum or phlegm			
Cough up blood			
Short of breath at rest			
Short of breath with exertion			
Wheezing			
Excessive snoring			
MUSCULOSKELETAL	**Y**	**N**	**O**
Joint pains			
Joint swelling			
Frequent backaches			
Fractures			
Dislocations			
Neck pain			
Back pain			
Other: _____			
ENDOCRINE	**Y**	**N**	**O**
History of thyroid problems			
Difficulty tolerating heat or cold			
Recent change in skin or hair			
HEMATOLOGIC/LYMPHATIC	**Y**	**N**	**O**
Easy bruising			
History of anemia			
History of blood transfusion			
Swollen lymph glands			
Other: _____			