Adult Annual Visit

MRN_____ **Today's Date** _____

Name_____ **Date of Birth**_____

List anyone else involved with your care including other medical providers:

_____

_____

SOCIAL HISTORY:

Marital Status: _____ **Do you have an Advance Directive? YES/NO**

Are you currently employed? YES / NO -- Occupation: _____

Describe your current physical activities: _____

Describe your current diet: _____

Tobacco Use:

Never: _____

Former Smoker: _____ **How Many?** _____ **Quit When?** _____

Current Smoker: _____ **How Many?** _____ **How Long?** _____

Interest in Quitting? YES / NO

Alcohol Use: How many drinks per week? _____

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or More
MEN: How many times in the past year have you had 5 or more drinks in a day?		
WOMEN: How many times in the past year have you had 4 or more drinks in a day?		

Recreational Drug Use:

Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

Are you currently using or have you ever used recreational drugs? YES / NO

If yes, what kind? _____ **For how long?**_____

DEPRESSION SCREENING:

Over the last 2 weeks, how often have you been bothered by any of the following:

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
	0	1	2	3
1. Little interest or pleasure in doing things:				
2. Feeling down, depressed or hopeless:				

ALLERGIES: (Please list any food or drug allergies)

_____

CURRENT MEDICATIONS: (Please include supplements and non-prescription medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

FAMILY HISTORY:

Have your parents, brothers, sisters or children ever been treated for (circle yes or no):

Cancer…… YES / NO Who? _____ **High Blood Pressure…… YES / NO Who?_____**

Nervous Disorders……..…. .YES / NO Who? _____ **Heart Disease…… YES / NO Who?_____**

Diabetes……....YES / NO Who? _____ **Blood Disease ……..…… YES / NO Who?_____**

HISTORY OF MEDICAL CARE:

Last Eye Exam: _____ **Last Colon Cancer Screening:_____**

<u>For women</u>:

Last Pap Smear:_____ **Last Mammogram:_____**

If you are 50 years old or under: Would you like to become pregnant in the next year?.....YES/NO

Current method of birth control: _____

PAST MEDICAL HISTORY:

Have <u>YOU</u> ever been treated for (circle yes or no):

Cancer…… YES / NO
Nervous Disorders……..…. YES / NO
Heart Disease…….…... YES / NO
Muscular Disorder…….. YES / NO
Glaucoma……... YES / NO
High Blood Pressure…… YES / NO
Hay Fever or Asthma…….. YES / NO
Blood Disease……. YES / NO
Kidney Trouble……. YES / NO
Diabetes…….…….. YES / NO

PAST SURGICAL HISTORY: (Please list all major surgeries)

_____

_____

_____

_____

HISTORY OF ILLNESSES AND CHRONIC MEDICAL PROBLEMS:

_____

_____

_____

REVIEWED BY: _____

DATE:_____

NEW PATIENT:
REVIEW OF SYSTEMS

MRN_____ **Today's Date** _____

Name _____ **Date of Birth** _____

(Please check all that apply):

CONSTITUTIONAL:
__ Fever
__ Feeling Poorly
__ Recent Weight Gain
__ Chills
__ Feeling Tired
__ Recent Weight Loss

EYES:
__ Eye Pain
__ Eyesight Problems
__ Dryness of the Eyes
__ Red Eyes
__ Discharge from the Eyes
__ Itching of the Eyes

ENT:
__ Earache
__ Nosebleeds
__ Sore Throat
__ Hearing Loss
__ Nasal Discharge
__ Hoarseness

CARDIOVASCULAR:
__ Chest Pain
__ Fast Heart Rate
__ Intermittent Leg Swelling
__ Palpitations
__ Slow Heart Rate

RESPIRATORY:
__ Shortness of Breath
__ Shortness of Breath w/Exertion
__ Cough
__ Trouble Breathing
__ Wheezing
__ Trouble Breathing w/Sleep

GASTROINTESTINAL:
__ Abdominal Pain
__ Constipation
__ Heartburn
__ Vomiting
__ Nausea
__ Diarrhea
__ Bright Red Blood Per Rectum
__ Difficulty Swallowing

GENITOURINARY:
__ Difficulty Urinating
__ Vaginal Discharge
__ Incontinence
__ Unexplained Vaginal Bleeding
__ Urinary Frequency
__ Feelings of Urgency

MUSCULOSKELETAL:
__ Joint Pain
__ Joint Swelling
__ Limb Pain
__ Joint Stiffness
__ Back Pain

INTEGUMENTARY:
__ Skin Lesion
__ Itchy Skin
__ Breast Pain
__ Breast Lump
__ Rash
__ Dry Skin

NEUROLOGIC:
__ Confusion
__ Dizziness
__ Limb Weakness
__ Fainting
__ Difficulty Walking
__ Numbness
__ Headache
__ Memory Lapse or Loss

PSYCHIATRIC:
__ Suicidal
__ Anxiety
__ Personality Change
__ Sleep Disturbances
__ Depression
__ Emotional Problems

ENDOCRINE:
__ Feelings of Weakness
__ Hot Flashes
__ Always Thirsty
__ Frequent Urination
__ Intolerance to Cold
__ Intolerance to Heat

HEMATOLOGIC / LYMPHATIC:
__ Easy Bleeding
__ Swollen Glands
__ Easy Bruising
__ Swollen Glands in Neck

ALLERGY / IMMUNOLOGIC:
__ History of Asthma
__ Hives
__ Eczema
__ Hay Fever

OTHER:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reviewing Physician: _____ **Date:**_____