

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Medical Record# \_\_\_\_\_

- Yes  No Require the frequent use of laxatives
- Yes  No Date of last stool test for blood
- Yes  No Date of last procto or flexible sigmoidoscopy
- Yes  No Burning pain when you urinate
- Yes  No Get up at night to urinate – How many times per night? \_\_\_\_\_
- Yes  No Difficulty beginning to urinate
- Yes  No Leaking urine
- Yes  No Leaking urine with cough or sneeze
- Yes  No Blood in urine

**WOMEN**

- Yes  No Gonorrhea/syphilis/herpes
- Yes  No Chlamydia/genital warts
- Yes  No Vaginal discharge
- Yes  No Menstrual irregularities
- Yes  No Discharge from nipple
- Yes  No Lump in breast
- Yes  No Family history of breast cancer
- Yes  No Number of pregnancies
- Yes  No Number of miscarriages
- Yes  No Problems with sexual activity

**MEN**

- Yes  No Gonorrhea/syphilis/herpes
- Yes  No Chlamydia/genital warts
- Yes  No Discharge from penis
- Yes  No Hernia
- Yes  No Prostate problems
- Yes  No Change in urinary stream
- Yes  No Problems with sexual activity
- Yes  No Date of last PSA blood test (prostate cancer screening)

Date of last menstrual period \_\_\_\_\_  
 Date of last Pap test for cancer \_\_\_\_\_  
 Date of last mammogram \_\_\_\_\_

- Yes  No Depression  Yes  No Anxiety panic attack
- Yes  No Schizophrenia  Yes  No Suicide attempt
- Yes  No Phobias

**CONTINUITY OF CARE**

Have you been shoved, hit, kicked, controlled or made to feel afraid within the last year? \_\_\_\_\_  
 Do you have difficulty handling your own affairs? \_\_\_\_\_  
 Do you need assistance with daily living? (circle appropriate)  
 Eating, Dressing, Bathing, Toilet Needs, Mobility  
 Do you come and go from home without assistance? \_\_\_\_\_  
 Do you have the help you need at home? \_\_\_\_\_  
 Do you have pets in your home? \_\_\_\_\_

**NUTRITION**

Do you have difficulty chewing or swallowing? \_\_\_\_\_  
 Have you had a weight gain or loss in the last year? \_\_\_\_\_ If yes, how many pounds? \_\_\_\_\_

**ADVANCE DIRECTIVES**

Do you have an Advance Directive? \_\_\_\_\_ If yes, does your doctor have the original copy? \_\_\_\_\_  
 If you do not have an Advance Directive, would you like to receive information? \_\_\_\_\_

**PRESENT PROBLEM**

Use space below to describe your symptoms or the reason for your present visit. If you have questions write them down so they will not be forgotten.

**AMBULATORY CARE HEALTH ASSESSMENT PROFILE**

FORM INITIATED: \_\_\_\_\_ DATE \_\_\_\_\_ PROVIDER SIGNATURE \_\_\_\_\_  
 UPDATED: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home#: \_\_\_\_\_  
 Business#: \_\_\_\_\_  
 D.O.B. \_\_\_\_\_ Medical Record# \_\_\_\_\_

Please complete this history form. This will allow us to best serve your health needs. The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

Today's Date: \_\_\_\_\_  
 Level of education completed \_\_\_\_\_ Occupation \_\_\_\_\_  
 Retire (yes/no) \_\_\_\_\_ Year \_\_\_\_\_ Marital status \_\_\_\_\_  
 Religion \_\_\_\_\_ Previous physician \_\_\_\_\_ Location of previous physician \_\_\_\_\_  
 Do you have cultural, ethnic, or religious beliefs that might alter treatment? \_\_\_\_\_  
 Do you have language, educational, or physical impairments that would impede communication/learning? \_\_\_\_\_

	Sex	Age	General Health	Age at Death	Cause of Death
Father					
Mother					
Brothers/Sisters	M F				
	M F				
	M F				
Sons/Daughters	M F				
	M F				
	M F				
Husband/Wife	M F				

Do you have any immediate family (living or deceased) with the following? (Indicate relationship)

- High Blood Pressure \_\_\_\_\_ Epilepsy \_\_\_\_\_
- Heart Attack \_\_\_\_\_ Asthma \_\_\_\_\_
- Stroke \_\_\_\_\_ Bleeding Problems \_\_\_\_\_
- Diabetes \_\_\_\_\_ Thyroid Problems \_\_\_\_\_
- Tuberculosis \_\_\_\_\_ Mental Illness \_\_\_\_\_
- Cancer, Leukemia \_\_\_\_\_ Kidney Disease \_\_\_\_\_
- High Cholesterol/Triglycerides \_\_\_\_\_ Other \_\_\_\_\_

**PERSONAL HABITS**

Yes	No	Do you smoke? cigarettes, pipe, cigar? _____ When?	Packs/day	Years
		Use chewing tobacco? _____		
		Do you drink coffee/tea? _____	Regular	Decaffeinated
		Do you drink alcohol? _____	1 oz./day	2 oz./day
		Do you drink beer? _____	1/day	2/day
		Do you use street drugs? _____	What?	How much/day
		Do you use stopped? _____	When?	More
		Do you use I.V. drugs? _____	What?	More
		Have you stopped? _____	When?	How often?

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**MEDICATIONS** (If more space is needed under any category please note on separate sheet of paper.)

Please list all the medications you take regularly. Include aspirin, decongestants, antacids, anti histamines, insulin, vitamins, birth control pills, tranquilizers, sleeping pills, herbs, etc. On the first visit please bring **all** your medications so we may review them with you.

Name	Size/Dose	How many times a day?

**ALLERGIES/ADVERSE DRUG REACTION**

List any medications, injections, food or latex that have given you bad reactions. If possible, include your reaction (hives, welts, rash, itching, headache, nausea, diarrhea, passed out, shock, shortness of breath.)

Name	Type of Reaction	Year

**PAST HISTORY**

Fill in this section as best you can recall.

Operations/Accidents	Year	Hospital	Surgeon

  

Hospitalization for Medical or Mental Illness	Year	Hospital	Physician

List medical problems not requiring hospitalization (chronic headaches, rheumatic fever, diabetes, high blood pressure, tuberculosis, hepatitis, kidney stones, gallstones, ulcers, heart disease, cancer, thyroid, etc.)

Problems	Year	Treatment	Physician

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**IMMUNIZATIONS**

- Have you ever had a positive TB skin test? \_\_\_\_\_ When? \_\_\_\_\_
- What year was your last tetanus shot? \_\_\_\_\_ When? \_\_\_\_\_
- Have you had the pneumonia shot? \_\_\_\_\_ When? \_\_\_\_\_
- Have you had the flu shot? \_\_\_\_\_ When? \_\_\_\_\_
- Have you had an MMR (measles, mumps & rubella) booster: \_\_\_\_\_ When? \_\_\_\_\_
- Have you had the Hepatitis B shots? \_\_\_\_\_ When? \_\_\_\_\_
- Have you ever had a blood transfusion? \_\_\_\_\_ When? \_\_\_\_\_
- Have you had any other immunizations? \_\_\_\_\_

**REVIEW OF BODY SYSTEMS**

Ht. \_\_\_\_\_ Present weight: \_\_\_\_\_ Approximate weight 1 year ago \_\_\_\_\_

**Within the past 6 months, if you have experienced any of the following, place a check next to the symptoms that apply.**

- Yes  No Chills/fever  Yes  No Difficulty hearing
- Yes  No Night sweats  Yes  No Wearing a hearing aid
- Yes  No Sleeplessness/Insomnia  Yes  No Change in level of energy
- Yes  No Severe headache  Yes  No Feelings of excessive cold or warmth
- Yes  No Double vision  Yes  No Change in hair (texture, falling out)
- Yes  No Blurred vision  Yes  No Weakness in arm/leg
- Yes  No Episode of partial blindness  Yes  No Slurred speech
- Yes  No Date of eye exam \_\_\_\_\_  Yes  No Passing out
- Yes  No Glasses  Yes  No Contacts  Yes  No Difficulty climbing stairs
- Yes  No Use of cane/walker/wheelchair  Yes  No
- Yes  No Hoarseness  Yes  No Frequent constipation
- Yes  No Persistent cough - How long? \_\_\_\_\_  Yes  No Frequent diarrhea
- Yes  No Cough up phlegm - How much per day? (teaspoon, tablespoon, 1/2 cup) \_\_\_\_\_  Yes  No Blood in stool
- Yes  No Cough up blood  Yes  No Black, tarry stool
- Yes  No Shortness of breath with activity - How far can you walk before stopping? \_\_\_\_\_
- Yes  No Seasonal allergies / hay fever
- Yes  No Asthma or wheezing
- Yes  No A job in a mine or industry with exposure to asbestos, silica or large amounts of dust
- Yes  No Exposure to tuberculosis
- Yes  No Do you wake up short of breath at night?
- Yes  No Sleeping on extra pillows to breathe easier
- Yes  No Swelling of the feet
- Yes  No Irregular heart rate, palpitations
- Yes  No Chest pain or chest pressure with walking or activity
- Yes  No Chest pain or chest pressure after eating or when upset
- Yes  No Pain in legs or calves when walking - At what distance \_\_\_\_\_
- Yes  No Activity limited by other symptoms - What: \_\_\_\_\_
- Yes  No History of high Cholesterol / Triglyceride level
- Yes  No Difficulty swallowing food
- Yes  No Abdominal pain
- Yes  No Heart burn
- Yes  No Pain relieved with antacids
- Yes  No Change in appetite
- Yes  No Pain with eating particular foods
- Yes  No Dietary restrictions
- Yes  No Therapeutic diet What type? \_\_\_\_\_