University Physicians
University of Missouri Health Care

Woodrail General Internal Medicine/Pediatrics

Name_____ Date_____
Date of Birth_____ Place of Birth_____
E-mail Address_____-_____
Preferred Method of Communication_____

Adult Health History for NEW Patients

Main reason for today's visit: _____

What are your health goals for the next year? _____

Where were you receiving your care before? _____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems: if none of the symptoms apply to you. List other concerns above.

General:
__Fever/ chills
__Night sweats
__Unexplained weakness
__Excessive fatigue
__Decreased activity
__Unexplained weight loss/ gain
__***No Problems***

Eye:
__Eye Mattering/Discharge
__Blindness
__Blurred/Double Vision
__Glasses/Contact Lenses
__***No Problems***

Ear/Nose/Throat:
__Nose Bleeds
__Nasal Congestion
__Sore Throat/Hoarseness
__Trouble Swallowing
__Hearing loss
__Ear pain
__Dental cavities
__***No Problems***

Skin:
__Rash
__Itching
__New Change in mole
__Hair Loss/Change
__Change in nails
__***No Problems***

Respiratory:
__Shortness of Breath
__Cough
__Wheezing
__Loud Snoring
__Short of breath – exercise
__Short of breath – lying down
__Coughing up Blood
__Coughing up Phlegm
__***No Problems***

Cardiovascular:
__Chest Pain/Discomfort
__Heart Palpitations
__Swelling in legs/feet
__***No Problems***

Gastrointestinal:
__Nausea/Vomiting
__Diarrhea
__Blood in Stools
__Hemorrhoids
__Constipation
__Abdominal Pain
__Heartburn/Reflux
__Indigestion
__Bloating
__Loss of bowel control
__Problems eating
__Loss of appetite
__Excessive gas
__Rectal Pain
__***No Problems***

Genitourinary:
__Leaking Urine
__Blood in Urine
__Nighttime Urination
__Urinating More Often
__Discharge: Penis or Vagina
__Concerns w/ Sexual Function
__Testicular Pain/lumps
__***No Problems***

Musculoskeletal:
__Back Pain
__Neck Pain
__Muscle Aches/Cramps
__Joint Pain
__Muscle Weakness
__Decreased Joint Motion
__Joint Stiffness
__***No Problems***

Hematologic/Lymphatic:
__Bruise Easily
__Bleeding Tendency
__Swollen glands
__***No Problems***

Endocrine:
__Heat Sensitivity
__Cold Sensitivity
__Excessive Thirst
__Excessive Hunger
__High/Low blood sugar
__***No Problems***

Neurological:
__Headache
__Memory loss/confusion
__Fainting
__Dizziness
__Numbness/Tingling
__Unsteady Gait
__Frequent Falls
__Tremors
__Seizures
__***No Problems***

Psychiatric:
__Anxiety/Stress/Irritability
__Sleep Problems
__Lack of Concentration
__Change in Behavior
__Change in Personality
__Anorexia
__Binging/Purging
__***No Problems***

Women Only:
__Pre-Menstrual Symptoms
__Excessive/Irregular Bleeding
__Hot Flashes/Night Sweats
__***No Problems***

Breasts:
__Breast Lump/Pain
__Nipple Pain
__Nipple discharge
__***No Problems***

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than Half the days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc… Use the back of this form if you need more room and let us know that you wrote there.

☐ **I TAKE NO MEDICATIONS** **Please List Your PHARMACY of Choice _____**

MEDICATION	DOSE (mg/pill)	HOW MANY TIMES PER DAY?

ALLERGIES: Please list all allergies or intolerance to medications: Please include type of reaction:

☐ **NO KNOWN ALLERGIES**

ALLERGIES:	TYPE OF REACTION:

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had in the past any of the following conditions?

√	CONDITION	COMMENTS	√	CONDITION	COMMENTS
	Alcohol/Drug Abuse			Gout	
	Allergy/Hay Fever			Gyn. Conditions (Endometriosis)	
	Anemia			Gyn. Conditions (Fibroids)	
	Anxiety			Hepatitis – Type A/Type B/Type C	
	Arthritis (Rheumatoid)			High Blood Pressure	
	Arthritis (Osteoarthritis)			High Cholesterol	
	Asthma			Inflammatory Bowel Disease	
	Atrial Fibrillation			Irritable Bowel Syndrome	
	Bipolar Disorder			Kidney Disease/Failure	
	Bladder Problems			Kidney Stones	
	Blood Clot (leg/lung)			Liver Disease	
	Blood Transfusion			Lupus	
	Breast Condition (benign)			Migraine/Tension Headaches	
	Cancer Breast			Osteoporosis	
	Cancer Colon			Pancreatitis	
	Cancer Lung			Pneumonia	
	Cancer Prostate			Prostate Enlargement/Nodules	
	Cancer (Other type)_____			Seizures/Epilepsy	
	Cataracts			Skin Condition (Eczema/Psoriasis)	
	Colon Polyp			Skin Cancer _____	
	Coronary Artery Disease/Heart Attack			Sleep Apnea	
	Depression			Stomach Ulcer	
	Diabetes (Adult Onset) (Type 2)			Stroke	
	Diabetes (Childhood Onset) (Type 1)			Overactive Thyroid/Hyperthyroidism	
	Diverticulosis			Low Thyroid/Hypothyroidism	
	Emphysema (COPD)			UTI	
	Fractures (broken bones)_____			Other (list)	
	Gallbladder Disease			Other (list)	
	Heartburn/Reflux (GERD)			Other (list)	
	Glaucoma			Other (list)	

SURGICAL HISTORY: Please check off any procedures or surgeries.. **[ ] None**

√	SURGICAL PROCEDURE	YEAR	COMMENTS
	Hernia Repair		
	Appendectomy (appendix removal)		
	Back/Neck (Spine) Surgery		
	Biopsy (Location)		
	Breast Biopsy/Surgery (Circle: Right/Left/Both)		
	Cataract (Circle: Right/Left/Both)		
	Colonoscopy/Sigmoidoscopy		
	EGD (Stomach Endoscopy)		
	Gastric band/bypass (Weight Loss Surgery)		
	Gallbladder Removal (Circle: Open or Laparoscopic)		
	Coronary Bypass or Stent		
	Heart Surgery (Other than Coronary Bypass)		
	Hip Surgery (Circle: Right/Left/Both)		
	Knee Surgery (Circle: Right/Left/Both)		
	Hysterectomy (Total or Partial)		
	Ovary Removal or Ligation ("Tubal")		
	Vasectomy		
	Other (List)		
	Other (List)		

FAMILY HISTORY – Please indicate which relative has had the following diseases (Parents and siblings are the most important)

ADOPTED? YES or NO (please circle) If yes and you do **not** know your family history, you may skip this section.

√	DISEASE	RELATIONSHIP (Father, Mother, Children, Grandparents, Aunt/Uncles, Other)	COMMENTS
	No significant history known		
	Alcoholism/Drug abuse		
	Alzheimer's Dementia		
	Asthma		
	Autoimmune Disease		
	Bleeding or Clotting Disorder		
	Cancer _____		
	Cancer _____		
	Colon Polyp		
	Coronary Artery Disease (Heart Attack, Angina)		Age of Onset_____
	Depression/Suicide/Anxiety		
	Diabetes – Type 1 (childhood onset)		
	Diabetes – Type 2 (adult onset)		
	Emphysema (COPD)		
	Genetic Disorder (explain)		
	Heart Failure (CHF)		
	Hepatitis (A, B, or C)		
	High Blood Pressure (Hypertension)		
	High Cholesterol		
	Hypothyroidism/Thyroid Disease		
	Kidney Disease		
	Migraine Headaches		
	Osteoporosis		
	Stroke		
	Other (please list)		

SOCIAL HISTORY:

TOBACCO USE:
Smoke cigarettes: [ ]NEVER [ ] NO [ ] YES
Other tobacco: [ ] Pipe [ ] Cigar [ ] Snuff [ ] Chew
Current smoker: Packs/day_____ # of years: _____
Quit Date: _____
How many years did you smoke? ___
How many packs a day did you smoke? _____

ALCOHOL USE:
Do you drink alcohol? [ ] No [ ] Yes
# of drinks per week: _____ [ ] Beer [ ] Wine [ ] Liquor

DRUG USE:
Do you use recreational drugs? [ ] No [ ] Yes
Use needles to inject drugs? [ ] No [ ] Yes
Abuse Prescription drugs? [ ] No [ ] Yes

SEXUAL ACTIVITY:
Sexually involved currently: [ ] No [ ] Yes
Birth control: [ ] None [ ] Condom [ ] Pill [ ] Diaphragm
[ ] Other:_____

EMPLOYMENT/PERSONAL:
Occupation (or prior occupation): _____
[ ]Retired [ ]Unemployed [ ]Leave of Absence [ ]Disabled
Employer: _____
Marital Status [ ] Single [ ] Married [ ] Divorced
[ ] Partner [ ] Widowed
Spouses/Partners Name: _____
Number of Children & Ages: _____
Number of Grandchildren:_____

Who lives at home with you? _____

HEALTH MAINTENANCE SCREENING TESTS:
Mammogram (Women Only): Date_____
Pap Smear (Women Only): Date_____
Bone Density Test (Women Only): Date_____
Lipid (cholesterol) Screening: Date_____
Colonoscopy or Sigmoidoscopy: Date_____

EXERCISE:
Do you exercise regularly? [ ] Yes [ ] No
What kind of exercise? _____
How many minutes? _____
How often?_____

DIET:
Are you following a special diet? [ ] No [ ] Yes
Type: _____
Would you like help with your diet? [ ] No [ ]Yes

SAFETY:
Do you use seatbelts consistently? [ ] Yes [ ] No
Home has a working smoke detector? [ ] Yes [ ] No
Is violence at home a concern for you? [ ] Yes [ ] No

WOMEN'S HEALTH HISTORY:
Total number of pregnancies: _____
Number of births: _____
Date of last menstrual period: _____
Age at beginning of periods (menstruation):_____
Age at end of periods (menopause): _____

EDUCATION:
High School Graduate? [ ] Yes [ ] No [ ] GED
Highest Educational Level: _____

IMMUNIZATIONS:
Check this box if you don't know the information **[ ]**
Please check off any vaccinations. Add year, if known.
Tetanus (Td)_____
Pneumovax (pneumonia)_____
Varicella (Chicken Pox) shot or illness _____
Hepatitis A _____
Hepatitis B_____
MMR_____
Meningitis_____
Zostavax (shingles) _____
HPV _____
Influenza (flu shot)_____

Thank you for taking the time to fill out this important health documentation.