Name: ______________________ Date of Birth: ______________

Address: ______________________

Local Phone Number: ______________ Alternative Phone Number: ______________

Please describe what problem or concern brought you to our office today:

❑ Primarily to establish care ❑ Other (please briefly describe): ______________

Special Communication Needs:

Language Preference:

If "yes" to any of the questions below, how can we assist?		
Visual Impairment	❑ Yes ❑ No	
Hearing Impairment	❑ Yes ❑ No	
Speech Impairment	❑ Yes ❑ No	
Cognitive Impairment	❑ Yes ❑ No	
Sensory Impairment	❑ Yes ❑ No	

Personal Health History

Please check past (P) or current (C) problems or conditions

❑ P ❑ C Hypertension	❑ P ❑ C Bowel/Digestive Problem
❑ P ❑ C High Cholesterol	❑ P ❑ C Atrial Fibrillation
❑ P ❑ C Diabetes	❑ P ❑ C Seizures
❑ P ❑ C Heart Attack or Angina	❑ P ❑ C Headaches
❑ P ❑ C Irregular Heart Rhythm	❑ P ❑ C Stroke
❑ P ❑ C Congestive Heart Failure	❑ P ❑ C Prostate Problem
❑ P ❑ C Emphysema or Chronic Bronchitis	❑ P ❑ C Breast Problem
❑ P ❑ C Pneumonia	❑ P ❑ C Urinary Tract Infections
❑ P ❑ C Gastroesophageal Reflux Disease	❑ P ❑ C Arthritis
❑ P ❑ C Asthma	❑ P ❑ C Thyroid Problem
❑ P ❑ C Osteoporosis/Osteopenia	❑ P ❑ C Bleeding Disorder
❑ P ❑ C Cancer, Type:	❑ P ❑ C Addiction Issues
❑ P ❑ C Stomach Ulcer	❑ P ❑ C Depression
❑ P ❑ C Kidney Disease, Type:	❑ P ❑ C Anxiety
	❑ P ❑ C Mental Illness
❑ P ❑ C Liver Disease, Type:	❑ P ❑ C Other:

Previous Surgical Procedures

Please check if you have had any of the following:

Procedure	Year
❑ Heart Surgery	
❑ Carotid Artery Surgery	
❑ Vascular Surgery / Stent	
❑ Abdominal Aneurysm Repair	
❑ Hysterectomy	
❑ Gallbladder Removed	
❑ Appendix Removed	
❑ Tonsillectomy	
❑ Joint Replacement	
❑ Hip ❑ Right ❑ Left	
❑ Knee ❑ Right ❑ Left	
❑ Spine Surgery ❑ Neck ❑ Back	
❑ Breast Cancer Surgery	
❑ Prostate Cancer Surgery	
❑ Hernia	
❑ Other: ______________	

Social History

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Life Partner

Live Here Year Round? ❑ Yes ❑ No If no, part time location:

Occupation: **Concerns:** ❑ Stress ❑ Hazardous substances ❑ Heavy Lifting

Tobacco Use: ❑ Never ❑ Quit (when) ________ ❑ Current Smoker – Packs/day, how many years?

Alcohol Use: ❑ No ❑ Yes If yes, how many drinks/how often?

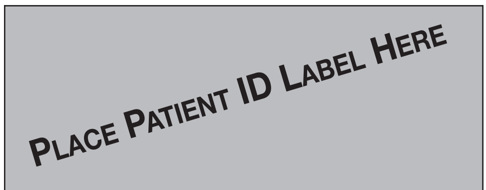
Caffeine Use: ❑ No ❑ Yes If yes – ❑ Coffee ❑ Soda ❑ Tea How many drinks/how often?

Illicit Drug Use (including Marijuana, Cocaine, Steroids)**:** ❑ Never ❑ Past ❑ Current
Describe:

SARASOTA MEMORIAL HEALTH CARE SYSTEM

NEWTOWN INTERNAL MEDICINE

ADULT HEALTH HISTORY QUESTIONNAIRE



Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

❑ Chest Pain	❑ Rectal Bleeding	❑ Eye Pain	❑ Nervousness
❑ Shortness of Breath	❑ Black/Tarry Stools	❑ Loss of Vision	❑ Pain in Testicles
❑ Wheezing	❑ Weight Loss	❑ Double Vision	❑ Loss of Libido
❑ Cough	❑ Weight Gain	❑ Memory Loss	❑ Impotence
❑ Coughing Up Blood	❑ Loss of Appetite	❑ Ringing in Ears	❑ Breast Pain
❑ Sore Throat	❑ Difficulty Swallowing	❑ Pain in Ears	❑ Breast Discharge
❑ Nasal Congestion	❑ Diarrhea	❑ Nose Bleeds	❑ Other (please describe below)
❑ Irregular Heartbeat	❑ Constipation	❑ Hoarseness	
❑ Fast Heartbeat	❑ Painful Urination	❑ Easy Bleeding	
❑ High Blood Pressure	❑ Blood in Urine	❑ Easy Bruising	
❑ Low Blood Pressure	❑ Urine Frequency	❑ Rash	
❑ Lightheadedness	❑ Decrease in Urine Flow	❑ Changes in Mole	**Females – Please Complete**
❑ Dizziness/Fainting	❑ Urine Leakage	❑ Sore that won't heal	Menstrual Flow: ❑ Reg ❑ Irreg. ❑ Pain/Cramps
❑ Abdominal Pain	❑ Headaches, frequent	❑ Fatigue / Lethargy	
❑ Heartburn	❑ Hemorrhoids	❑ Insomnia	Days of flow____ Length of cycle____
❑ Indigestion	❑ Loss of Strength	❑ Forgetfulness	1st day of last period:
❑ Ankle Swelling	❑ Balance Problems	❑ Depression	❑ Pain or bleeding after sex

❑ Nausea	**Pain, weakness or numbness in**			Number of pregnancies:
❑ Vomiting	❑ Arms	❑ Hips	❑ Back	Miscarriages:
❑ Vomiting Blood	❑ Legs	❑ Neck	❑ Shoulders	Birth Control Method:
❑ Change in Bowel Habits	❑ Hands	❑ Feet	❑ Abdomen	Menopause ❑ Y ❑ N Age:

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
❑ Mental Illness		❑ Chemical Dependency	
❑ Diabetes		❑ Stroke	
❑ Thyroid Disease		❑ Arthritis	
❑ Pituitary Disease		❑ Dementia	
❑ Crohn's / Colitis		❑ Hypertension	
❑ Cancer, Type:		❑ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

PLACE PATIENT ID LABEL HERE

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations	Last Occurrence	Tests	Last Occurrence
Tetanus Vaccine / Tdap ❑ Yes ❑ No		Pap Smear / Pelvic ❑ Yes ❑ No	
Pneumonia Vaccine ❑ Yes ❑ No		Mammogram ❑ Yes ❑ No	
Influenza Vaccine ❑ Yes ❑ No		Bone Density ❑ Yes ❑ No	
Shingles Vaccine ❑ Yes ❑ No		Colonoscopy ❑ Yes ❑ No	
Hepatitis ❑ A ❑ B ❑ Yes ❑ No		Prostate Test ❑ Yes ❑ No	
Guardasil (HPV) ❑ Yes ❑ No		Chest X-Ray ❑ Yes ❑ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for Admission

Allergies

Please list any allergies to medications or foods

Name	Symptom / Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy:______________________________ Phone:________________ Store #: __________

Location Description: ____

PLACE PATIENT ID LABEL HERE

Specialty Providers

In order that we can best coordinate your care, please list any medical providers you see outside of this practice

Cardiologist Name: ______ Phone: ______ Last Seen: ______	**Nephrologist** Name: ______ Phone: ______ Last Seen: ______
Opthalmologist Name: ______ Phone: ______ Last Seen: ______	**Psychiatrist / Psychologist** Name: ______ Phone: ______ Last Seen: ______
Oncologist Name: ______ Phone: ______ Last Seen: ______	**Allergist** Name: ______ Phone: ______ Last Seen: ______
Urologist Name: ______ Phone: ______ Last Seen: ______	**Gynecologist** Name: ______ Phone: ______ Last Seen: ______
Gastroenterologist Name: ______ Phone: ______ Last Seen: ______	**Pulmonologist** Name: ______ Phone: ______ Last Seen: ______
Endocrinologist Name: ______ Phone: ______ Last Seen: ______	**Podiatrist** Name: ______ Phone: ______ Last Seen: ______
Other: ______ Name: ______ Phone: ______ Last Seen: ______	**Other:** ______ Name: ______ Phone: ______ Last Seen: ______
Other: ______ Name: ______ Phone: ______ Last Seen: ______	**Other:** ______ Name: ______ Phone: ______ Last Seen: ______

Patient / Guardian Signature: ______ Date: ______ Time: ______ AM / PM