

Name \_\_\_\_\_

Date \_\_\_\_\_

### Adult Health History for NEW Patients

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you are a current patient there is a shorter update form you can use. Please fill in all five pages. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: \_\_\_\_\_

Other concerns: \_\_\_\_\_

What are your health goals for the next year? \_\_\_\_\_

Where were you getting your care before? \_\_\_\_\_

In the past 2 weeks, have you been bothered by:

Little interest or pleasure in doing things?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Feeling down, depressed or hopeless?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**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*

- Unexplained weight loss / gain
- Unexplained fatigue / weakness
- Fall asleep during day when sitting
- Fever, chills
- No problems**

*Skin*

- New or change in mole
- Rash / itching
- No problems**

*Breast*

- Breast lump / pain / nipple discharge
- No problems**

*Ears/Nose/Throat*

- Nosebleeds, trouble swallowing
- Frequent sore throat, hoarseness
- Hearing loss / ringing in ears
- No problems**

*Eyes*

- Change in vision / eye pain / redness
- No problems**

*Cardiovascular*

- Chest pain / discomfort
- Palpitations (fast or irregular heartbeat)
- No problems**

*Respiratory*

- Cough / wheeze
- Loud snoring / altered breathing during sleep
- Short of breath with exertion
- No problems**

*Gastrointestinal*

- Heartburn / reflux / indigestion
- Blood or change in bowel movement
- Constipation
- No problems**

*Genitourinary*

- Leaking urine
- Blood in urine
- Nighttime urination or increased frequency
- Discharge: penis or vagina
- Concern with sexual function
- No problems**

*Musculoskeletal*

- Neck pain
- Back pain
- Muscle / joint pain \_\_\_\_\_
- No problems**

*Endocrine*

- Heat or cold sensitivity
- No problems**

*Hematologic/Lymphatic*

- Swollen glands
- Easy bruising
- No problems**

*Neurological*

- Headache
- Memory loss
- Fainting
- Dizziness
- Numbness / tingling
- Unsteady gait
- Frequent falls
- No problems**

*Allergic/Immune*

- Hay fever / allergies
- Frequent infections
- No problems**

*Psychiatric*

- Anxiety / stress / irritability
- Sleep problem
- Lack of concentration
- No problems**

*Women only*

- Pre-menstrual symptoms (bloating cramps, irritability)
- Problem with menstrual periods
- Hot flashes / night sweats
- No problems**

**IMMUNIZATIONS:** Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information.

Tetanus (Td) \_\_\_\_\_ With Pertussis (Tdap) \_\_\_\_\_ Varicella (Chicken Pox) shot *or* illness \_\_\_\_\_ Pneumovax (pneumonia) \_\_\_\_\_

Influenza (flu shot) \_\_\_\_\_ Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ MMR \_\_\_\_\_ Meningitis \_\_\_\_\_ Zostavax (shingles) \_\_\_\_\_ HPV \_\_\_\_\_

**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 you wrote there.

TAKE NO MEDICATIONS

Medication \_\_\_\_\_ Dose (e.g. mg/pill) \_\_\_\_\_ How many times per day? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies or intolerance to medications (include type of reaction): \_\_\_\_\_  NONE

**HEALTH MAINTENANCE SCREENING TESTS:**

Lipid (cholesterol) Date \_\_\_\_\_ Abnormal?  No  Yes  
 Sigmoidoscopy or Colonoscopy (circle one) Date \_\_\_\_\_ Polyp?  No  Yes

*Women only:*  
 Mammogram Date \_\_\_\_\_ Abnormal?  No  Yes  
 Pap Smear Date \_\_\_\_\_ Abnormal?  No  Yes  
 Bone Density Test Date \_\_\_\_\_ Abnormal?  No  Yes

**PERSONAL MEDICAL HISTORY:** Do you have now (current) or have you had (past) any of the following conditions?  NONE

Condition	Code	Current	Past	Comments
Alcohol / Drug abuse	305.00/305.90			
Allergy (Hay Fever)	477.9			
Anemia	285.9			
Anxiety	300.00			
Arthritis (Rheumatoid)	714.0			
Arthritis (Osteoarthritis)	715.90			
Asthma	493.90			
Bladder / Kidney Problems				
Blood Clot (leg)	453.40			
Blood Clot (lung)	415.11			
Blood Transfusion	V58.2			
Breast Lump (benign)	611.72			
Cancer Breast	174.9			
Cancer Colon	153.9			
Cancer Other Type				
Cancer Ovarian	183.0			
Cancer Prostate	185			
Cataracts	366.9			
Chicken Pox	052.9			
Colon Polyp	211.3			
Coronary Artery Disease	414.00			
Depression	311			
Diabetes (adult onset)	250.00			
Diabetes (childhood onset)	250.01			
Diverticulosis	562.10			
Emphysema	492.8			
Fractures (broken bones)				Where?
Gallbladder Disease	574.20			
Gastroesophageal Reflux (Heartburn/GERD)	530.81			
Glaucoma	365.9			

<b>PERSONAL MEDICAL HISTORY Continued:</b> <i>Condition</i>	<i>Code</i>	<i>Current</i>	<i>Past</i>	<i>Comments</i>
Gout	274.9			
Gynecological Conditions (Endometriosis)	617.9			
Gynecological Conditions (Fibroids)	218.9			
Gynecological Conditions (Other)				
Heart Attack	410.90			
Hepatitis – Type A	070.1			
Hepatitis – Type B	070.30			
Hepatitis – Type C	070.51			
Hepatitis – Other	070.59			
High Blood Pressure	401.9			
High Cholesterol	272.0			
Hip Fracture	820.8			
Irritable Bowel Syndrome	564.1			
Kidney Disease / Failure	586			
Kidney Stones	592.0			
Liver Disease	573.9			
Migraine Headaches	346.90			
Osteoporosis	733.00			
Pneumonia	486			
Prostate (enlargement)	600.00			
Prostate (nodules)	600.10			
Seizure / Epilepsy	780.39			
Skin Condition (Eczema)	692.9			
Skin Condition (Psoriasis)	696.1			
Skin Condition (Abnormal Moles)	238.2			
Sleep Apnea	780.57			
Stomach Ulcer	531.90			
Stroke	434.91			
Thyroid (Nodule)	241.0			
Thyroid High (Overactive) / Hyperthyroidism	242.90			
Thyroid Low (Underactive) / Hypothyroidism	244.9			
Other (list)				
Other (list)				

**SURGICAL HISTORY** – Please check off any procedure or surgeries. List any abnormal finding or complications.  **NONE**

<i>Surgical Procedure</i>	<i>Code</i>	<i>Yes</i>	<i>Year</i>	<i>Comments</i>
Abdominal Surgery				
Appendectomy (appendix removal)				
Back Surgery (lumbar)				
Biopsy (location)				
Breast Biopsy				Circle: Right Left Both
Breast Surgery				Circle: Right Left Both
Colonoscopy				
Coronary Bypass				
Coronary Stent				
EGD (Stomach Endoscopy)				
Cataract				
Gallbladder Removal				Circle: Laparoscopic
Heart Surgery (other than coronary bypass)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal

<b>SURGICAL HISTORY Continued:</b> <b>Surgical Procedure</b>	<b>Code</b>	<b>Yes</b>	<b>Year</b>	<b>Comments</b>
Knee Surgery				Circle: Right Left Both
LEEP (Cervix Surgery)				
Neck Surgery				
Ovary Ligation ("Tubal")				
Ovary Removal				Circle: Right Left Both
Vasectomy				
Sigmoidscopy				
Sinus Surgery				
Other (list)				

Adopted – Yes No (Please Circle) If yes and you do not know your family history skip this section and continue to page 5 (Other Health Issues)

**FAMILY HISTORY** – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
<b>No significant history known</b>										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Other Type										
Cancer Ovarian										
Cancer Prostate										
Colon Polyp										
Coronary Artery Disease (e.g. heart attack, angina)										
Depression / Suicide / Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
High Blood Pressure - Hypertension										
High Cholesterol										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (list)										

**OTHER HEALTH ISSUES:**

**Tobacco Use**

Smoke cigarettes:  Never  No  Yes  
(If you never smoked please go to alcohol use question now)

Quit date: \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

Approximately how many packs a day did you smoke? \_\_\_\_\_

Current smoker: Packs/day: \_\_\_\_\_ # of years: \_\_\_\_\_

Other tobacco:  Pipe  Cigar  Snuff  Chew

**Alcohol Use**

Do you drink alcohol?  No  Yes

# of drinks/week: \_\_\_\_\_  Beer  Wine  Liquor

**Drug Use**

Do you use marijuana or recreational drugs?  No  Yes

Have you ever used needles to inject drugs?  No  Yes

**Sexual Activity**

Sexually involved currently:  No  Yes

Sexual partner(s) is/are/have been:  male  female

Birth control method (circle below all that apply):  None needed

Condom, pill, diaphragm, vasectomy, other \_\_\_\_\_

**Exercise:** Do you exercise regularly?  Yes  No

What kind of exercise? \_\_\_\_\_

How long (minutes)? \_\_\_\_\_ How often? \_\_\_\_\_

**Diet:** How would you rate your diet?  Good  Fair  Poor

Would you like advice on your diet?  No  Yes

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?

(Circle above all that apply)  Yes  No

**SOCIAL HISTORY:**

Occupation (or prior occupation): \_\_\_\_\_ retired/unemployed/leave of absence/disabled (circle one)

Employer: \_\_\_\_\_ Years of education or highest degree: \_\_\_\_\_

Marital status (circle one): single, partner, married, divorced, widowed, other: \_\_\_\_\_

Spouse/partner's name: \_\_\_\_\_ Number of children: \_\_\_\_\_ Ages if under 18 years: \_\_\_\_\_

Number of grandchildren: \_\_\_\_\_ Number of great grandchildren: \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

Leisure activities, group involvement, religion, volunteer work, recent travel: \_\_\_\_\_

**WOMEN'S HEALTH HISTORY:**

Total number of pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_

Date (month/day if known) of last menstrual period if you are still menstruating: \_\_\_\_\_

Age at beginning of periods (menstruation): \_\_\_\_\_

Age at end of periods (menopause): \_\_\_\_\_

Thank-you for taking the time to fill this out.

Family Medicine at Sterling Ridge  
 10110 Woodlands Parkway, Suite 100  
 The Woodlands, TX 77382  
**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Over the last 2 weeks, how often have you been bothered by any of the following problems?  
 (Use "X" to indicate your answer)**

	Not at all	Several days	More than half the days	Nearly everyday
	0	1	2	3
1. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep or sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself or that you are a failure or have let yourself or you family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Total Score**

**Interpretation:**

- Minimal Depression
- Mild Depression
- Moderate Depression
- Moderately Severe Depression
- Severe Depression

**Interpretation of Total Score for Depression Severity:**

- 1-4 Minimal depression
- 5-9 Mild Depression
- 10-14 Moderate Depression
- 15-19 Moderately Severe Depression
- 20-27 Severe Depression

**If any of the below screenings have been completed, please provide copy of the results to our office:**

Breast Cancer Screening / Mammogram	Yes / No	Date Performed: _____	Normal / Abnormal
Colorectal Cancer Screening / Colonoscopy	Yes / No	Date Performed: _____	Normal / Abnormal
Diabetic Eye Exam	Yes / No	Date Performed: _____	Normal / Abnormal
Bone Density	Yes / No	Date Performed: _____	Normal / Abnormal
Pap Smear	Yes / No	Date Performed: _____	Normal / Abnormal