LEXINGTON FAMILY PHYSICIANS

Adult Initial Health History

Name _____
First Middle Last

Today's Date_____Date of Birth _____

Address_____

Telephone Number (home)(_____)_____
(cell) (_____)_____
(email address)_____

Filling out this form

- Answering these questions will help your doctor understand your health and how best to treat you.
- If you need help filling out this form:
    - Bring this form with you to your appointment and a nurse will help you.

OR

    - Call the clinic at [336-249-3329] before your appointment and someone can help you over the phone.

Bring to your appointment:

1. This **Initial Health History Form** and any other important **medical records**

2. Your **insurance information**

3. All **your medicines** (prescription, herbal, over-the-counter pills and creams)

We look forward to working with you!

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GENERAL HEALTH

1. **Why did you make this appointment**? (Check all that apply.)

☐ regular checkup
☐ first appointment to start care with a new doctor
☐ switching doctors (from whom: _____)
☐ have a specific health problem (if so, explain _____)

2. In general, what do you consider to be your **main health problem**(s)? (Check all that apply.)

☐ heart problems
☐ stomach problems
☐ ear, nose, or throat problems
☐ high blood pressure
☐ diabetes
☐ depression/emotional problems
☐ joint problems
☐ Other(s) – please explain_____

_____

3. How would you **describe your health**?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. Are you taking any **prescription medicines**?

☐ Yes. Please list your medicines below OR ☐ I brought my pill bottles or a list.
☐ No, I do not take any prescription medicines. (If no, go to question #5.)

Name of medicine	**Amount / size of pill**	**How many pills or doses do you take at**
Example: Furosemide	20 mg	2 morning 2 noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed

(Please use the back of this form if you have more prescription medicines.)

5. What **over-the-counter medicines**, do you take regularly?

☐ Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, aspirin)
☐ Vitamins
☐ Antacid (for example: Tums, Prilosec)
☐ Herbal medicine (please list) _____
☐ Other (please list) _____
☐ None - I do not take any over-the-counter medicines regularly.

6. Have you ever had any **allergic reaction (bad effects) to a medicine** or a shot?
☐ Yes. (Please write the name of the medicine and the effect you had.)
☐ No, I am not allergic to any medicines.

Medicine I am allergic to	**What happens when I take that medicine**
Example: Atenolol	I get a rash

7. Do you get an **allergic reaction (bad effect)** from any of the following? (Check all that apply)
☐ latex (rubber gloves)
☐ grass or pollen
☐ eggs
☐ shellfish
☐ Other (please describe) _____
☐ No - I have no allergies that I know of.

8. Have you ever been a **patient in a hospital** overnight?
☐ Yes. (If yes, explain EACH reason and when.)
☐ No, I have never been a patient in a hospital. (If no, go to question #9)

I was in the hospital because:	**When**
Example: Heart Attack	6 years ago

9. Have you ever had a **colonoscopy** (a test to look at your insides by sending a camera through your bottom)?..... …….....☐ Yes ☐No
When _____

10. Have you ever received a **blood transfusion** (when you are given extra blood)? ……☐ Yes ☐No
When_____

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FOR WOMEN ONLY

11. Have you ever been **pregnant**? ……☐ Yes ☐No
How many times?_____
How many children have you given birth to?_____

12. Have you had a **PAP smear**? ……☐ Yes ☐No
Date of last one _____

13. Have you ever had a **PAP smear that was not normal**? ……☐ Yes ☐No

14. Have you had a **mammogram** (breast x-ray)?.....☐ Yes ☐No
Date of last one_____

SHOTS

15. When was your last **Tetanus shot**?.....Year_____ ☐never ☐ don't know

16. When was your last **Pneumonia shot**?..... Year_____ ☐never ☐ don't know

17. When was your last **Flu shot**?..... Year_____ ☐never ☐ don't know

SOCIAL HISTORY

18. Circle the **highest grade** you finished in school?

1 2 3 4 5 6 7 8	9 10 11 12	GED	1 2 3	1 2 3 4+
Grade School	High School		Vocational School	College

19. What **language** do you prefer to speak? ☐ English ☐Spanish ☐Other _____

20. How well can you **read**?

☐ Very well ☐ Well ☐ Not well ☐ I can not read

21. **What do you do during the day**?
☐ Work full-time
☐ Work part-time
☐ Attend school
☐ Take care of children at home
☐ Go out most days (shop, visit, appointments)
☐ Stay home most days
☐ Other_____

22. Have you **ever smoked cigarettes, cigars, used snuff, or chewed tobacco**?
☐ No (if no, go to question #23.)
☐ Yes
a. When did you start?_____
b. How much per week? _____
c. Have you quit?.....☐ No ☐ Yes, when_____
d. Do you want to quit?.....☐ No ☐Yes ☐ Already Quit

23. Do you drink **alcohol**?
☐ No (if no, go to question #24.)
☐ Yes
a. Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐No
b. Have people ever annoyed you by criticizing your drinking? ☐ Yes ☐No
c. Have you ever felt bad or guilty about your drinking? ……...☐ Yes ☐No
d. Have you ever had a drink first thing in the morning? ……...☐ Yes ☐No

24. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed?

25. Who lives in your house?_____
_____

26. Do you have **sex** with ☐ men ☐ women ☐ both ☐ neither

27. Do you have any **beliefs or practices from your religion, culture, or otherwise** that your doctor should know? For example:
☐ I am a **Jehovah's Witness** and do not accept blood/blood products.
☐ I **do not use birth control** because of personal or religious beliefs.
☐ I **fast** (go without food) for periods of time for personal or religious reasons.
☐ I am a **vegetarian** (do not eat meat.)
☐ I am a **vegan** (do not eat anything that comes from an animal.)
☐ Other special diets or eating habits. (Please describe.) _____
☐ I use traditional medicines or treatments, such as acupuncture or herbs.
☐ Other beliefs_____
☐ **No**, I have no beliefs or practices that need to be included in my care.

28. Check any of the following things you use to **help you walk**.
☐ Cane ☐ Walker ☐ Wheelchair
☐ Other _____
☐ I do not need any help walking

29. Check any of the following types of **help at home** you receive (paid help or family and friends).

☐ Help with cleaning/laundry.
☐ Help with shopping.
☐ Help with personal care (bathing, dressing).
☐ Help with taking my medications.
☐ I do not use any help at home.

30. In the past year, have you been **emotionally or physically abused** by your partner or someone important to you?..... ☐ Yes ☐ No

31. In the past year have you been **hit, pushed, shoved, kicked or threatened** by a partner or someone important to you?……...☐ Yes ☐ No

32. **EXERCISE**

Describe what kind of exercise you do. (Check all that apply.)	**How many days per week do you exercise?**	**For how long do you exercise <u>each day</u>?**
☐ walking ☐ biking ☐ swimming ☐ weight training ☐ yoga ☐ other ☐ I do not exercise	☐ once per week ☐ twice per week ☐ 3 times a week ☐ 4 times a week ☐ 5 times a week ☐ 6 times a week ☐ 7 times a week or more	☐ less than 15 minutes ☐ 15-30 minutes ☐ 30 – 45 minutes ☐ 45 minutes – 1 hour ☐ over 1 hour
Comments:		

FAMILY HISTORY

What medical problems do people in your family have?

Family Member	**Medical Problems**
Mother:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: _____
Father:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: _____
Sisters:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: _____
Brothers:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: _____

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HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check all that apply)

☐ Anemia (low iron blood)	☐ Asthma (wheezing)	☐ Diabetes (sugar)
☐ Heart Trouble	☐ Hemorrhoids (piles)	☐ Cancer
☐ Hepatitis (yellow jaundice)	☐ Tuberculosis (TB)	☐ Liver Trouble
☐ Pneumonia	☐ Rheumatic fever	☐ Ulcers
☐ Stroke	☐ High Blood Pressure	
☐ Skin problems	☐ Depression (feeling down or blue)	
☐ Epilepsy (fits, seizures)	☐ Anxiety (nerves, panic attacks)	

☐ VD, STD (syphilis, gonorrhea, chlamydia, HIV)

☐ Other_____

REVIEW OF SYMPTOMS

		YES	NO
Sleeping	Do you **feel tired** a lot?	☐ yes	☐ no
	Do you have **trouble falling or staying asleep**?	☐ yes	☐ no
	Do you have **other problems with sleep**?	☐ yes	☐ no
Eating	Have you **lost your appetite** recently?	☐ yes	☐ no
	Have you **lost weight** in the last year without trying?	☐ yes	☐ no
	Do you **eat too much** or **have you gained weight** recently?	☐ yes	☐ no
	Do you have **other problems with eating**?	☐ yes	☐ no
Throat	Do you have **sore throats** a lot?	☐ yes	☐ no
	Do you have **other problems with your throat**?	☐ yes	☐ no
Ears	Do you have **trouble hearing**?	☐ yes	☐ no
	Do you wear a **hearing aid**?	☐ yes	☐ no
	Do you have constant **ringing or noises** in your ears?	☐ yes	☐ no
	Do you have **other problems with your ears?**	☐ yes	☐ no
Back	Do you have **back pain**?	☐ yes	☐ no
	Do you have any **other problems with your back**?	☐ yes	☐ no

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Eyes	Do you have **trouble with your vision** or seeing?	☐ yes	☐ no
	Do you wear **glasses or contacts**?	☐ yes	☐ no
	Do you have **other problems with your eyes**?	☐ yes	☐ no
Nose and Sinuses	Do you have a **runny or stopped up nose** a lot?	☐ yes	☐ no
	Do you have **other problems with your nose or sinuses?**	☐ yes	☐ no
Teeth and Mouth	Do you have **sore or bleeding gums**?	☐ yes	☐ no
	Do you wear **plates or false teeth**?	☐ yes	☐ no
	Do you have **other problems with your teeth and mouth?**	☐ yes	☐ no
Heart or Breathing	Do you ever have **pain/tightness in your chest** when working or exercising?	☐ yes	☐ no
	Do you **wake up at night with trouble breathing**?	☐ yes	☐ no
	Do you have a **racing or skipping heartbeat** at times?	☐ yes	☐ no
	Do you have **other heart or breathing problems**?	☐ yes	☐ no
Bowel movements	Do you have **bowel movements (poop) that are black, like tar, or bloody?**	☐ yes	☐ no
	Do you have **any other problems with your bowel movements (poop)?**	☐ yes	☐ no
Peeing and Kidney Stones	Do you have **trouble passing your urine (peeing)?**	☐ yes	☐ no
	Does it **burn when you pass urine (pee)?**	☐ yes	☐ no
	Do you have to **pee more than 2 times a night**?	☐ yes	☐ no
	Do you **leak urine (pee)?**	☐ yes	☐ no
	Have you ever passed **kidney stones**?	☐ yes	☐ no
	Do you have any **other problems with your peeing**?	☐ yes	☐ no
Joints	Do you have **swollen or painful joints**?	☐ yes	☐ no
	Do you have any **other problems with your joints**?	☐ yes	☐ no

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Head, Balance, Fever and Weakness	Do you have **frequent or severe headaches**?	☐ yes	☐ no
	Have you ever **fainted (passed out)**?	☐ yes	☐ no
	Have you **lost your balance and fallen** recently?	☐ yes	☐ no
	Do you have **weakness** in any part of your body?	☐ yes	☐ no
	Have you had a **fever** within the past month?	☐ yes	☐ no
	Do you have any **other problems with your head or balance?**	☐ yes	☐ no
Emotional Health	Do you get **upset easily**?	☐ yes	☐ no
	Do **frightening thoughts** keep coming into your mind?	☐ yes	☐ no
	Have you ever been **hospitalized for nerves, thoughts or moods**?	☐ yes	☐ no
	During the past 2 weeks, have you often been bothered by having **little interest or pleasure in doing things**?	☐ yes	☐ no
	During the past 2 weeks, have you often been bothered by feeling **down, depressed, or hopeless**?	☐ yes	☐ no
	Do you have any **other problems with your emotional health?**	☐ yes	☐ no
Men Only	Have you ever had **prostate trouble**?	☐ yes	☐ no
	Do you have any **other male problems**?	☐ yes	☐ no
Women Only	Do you have **pain or lumps in your breast**?	☐ yes	☐ no
	Do you have unusual **vaginal discharge or itching**?	☐ yes	☐ no
	Do you or have you taken **hormones (such as birth control pills)**?	☐ yes	☐ no
	Do you have any **other female problems**?	☐ yes	☐ no