## Adult Patient Demographics

Patient's Name: _______________________________________________ Previous or Nickname: _____________________________

Sex:☐ Male ☐ Female Social Security Number ________ - ________ - __________ Date of Birth**:** ________________________

Mailing Address: _______________________________________________________________________________________________

City State Zip Code

Home Phone #: (______) ______ - __________May we leave a message? ☐ Yes ☐ No

Cell Phone #: (_______) ______ - __________May we leave a message? ☐ Yes ☐ No

Email Address: _________________________________________________________________________________________________

Race**:** ☐ White ☐ Black/African American
☐ American Indian/Alaskan Native
☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ Unknown ☐ Refuse to Report

Ethnicity**:** ☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown ☐ Refuse to Report

Marital Status: _________________ Primary Language**:** ☐ English ☐ Spanish ☐ Other: _____________ ☐ Refuse to Report

**EMPLOYMENT:**
Employment Status: _______________ Employer's Name: ________________________ Occupation: _______________________
Retirement Date: __________________Address: ____________________________________________________________________
City State Zip Code Phone #

**INSURANCE INFORMATION:**
*Primary Insurance Company's Name*: ___________________________________________________________________________

Name as it Appears on the Card: _______________________________________________________________________________

Cardholder's Date of Birth: _____ / _____ / ______________

Cardholder's Social Security #: ________ - ________ - ________

Member ID #: ___________________________________ Group Name or #: _________________________________

*Secondary Insurance Company's Name*: ___________________________________________________

Name as it Appears on the Card: ___________________________________________________________

Cardholder's Date of Birth: _____ / _____ / _____________

Cardholder's Social Security #: ________ - ________ - ________

Member ID #: ___________________________________ Group Name or #: _________________________________

**EMERGENCY CONTACT:**
Name: ______________________________________________ Relationship: _____________________________________

Home Phone #: (______) ______ - ______________________ Additional Phone #: (______) ______ - _______________

**Patient Signature:** _________________________________________________________ **Date:** _____ **/** ______**/**________

Reviewed/Revised 03/23/2016, 11/04/2016, 3/11/2019

# PATIENT HEALTH HISTORY: ADULT

Your answers on this form will help your healthcare team obtain an accurate history of your medical concerns and conditions. Please do your best to complete all four pages. If you cannot remember specific details or if you have questions/concerns about the information we are requesting, please speak with your healthcare team.

**Personal Medical History:** Please indicate with an **X** if you have had the following:

| **Condition:** | **X** | **Condition:** | **X** | **Condition:** | **X** |
|---|---|---|---|---|---|
| **CARDIOVASCULAR** | | **BLOOD CONDITION** | | **CANCER** | |
| Atrial Fibrillation | | Anemia | | Blood/ Leukemia | |
| Congestive Heart Failure | | Blood Transfusion | | Brain | |
| Heart Attack | | Blood Clot | | Breast | |
| High Cholesterol | | | | Colon | |
| Hypertension | | **EMOTIONAL/BEHAVIORAL** | | Lung | |
| | | Alcoholism | | Ovarian | |
| **EYES/EARS** | | Alzheimer’s Disease | | Prostate | |
| Blindness | | Anxiety | | Other: | |
| Cataract | | Attention Deficit Disorder | | | |
| Glaucoma | | Bipolar Disorder | | **ENDOCRINOLOGY/RENAL** | |
| Hay Fever | | Depression | | Chronic Renal Failure | |
| Hearing Loss | | Drug Use | | Diabetes Type 1 | |
| | | Eating Disorder | | Diabetes Type 2 | |
| **GASTROINTESTINAL** | | Memory Problems | | Dialysis | |
| Celiac Disease | | Post-Traumatic Stress Disorder | | Kidney Disease/Kidney Stone | |
| Colitis | | Schizophrenia | | Thyroid Disorder | |
| Colon Polyps | | | | Urinary Tract Infection-frequent | |
| Crohn’s Disease (Granulomatous) | | **MUSCULOSKELETAL** | | | |
| Diverticulitis | | Arthritis | | **NEUROLOGICAL** | |
| Gastrointestinal Bleeding | | Back/Neck Injury | | Migraine/Headaches | |
| GERD (heart burn/reflux) | | Carpal Tunnel Syndrome | | Seizure Disorder | |
| Hemorrhoid | | Chronic Pain | | Stroke | |
| Hepatitis | | Gout | | Tremor | |
| Irritable Bowel Syndrome | | Osteoporosis | | | |
| Liver Disease | | | | **OTHERS** | |
| Pancreatitis | | **RESPIRATORY** | | Autoimmune Disorder | |
| | | Asthma | | Erectile Dysfunction | |
| **PREGNANCY** | | COPD (Emphysema) | | Fibromyalgia | |
| Number of pregnancies: | | Pneumonia | | HIV | |
| Number of live births: | | Pulmonary Embolism | | Skin Condition | |
| | | Respiratory Disorder | | | |
| | | Sleep Apnea | | | |
| | | Tuberculosis | | | |

**Please List Your Preferred Pharmacy**:______________________________**Location:**____________________________

Patient Name: ______________________________________________ Date of Birth: ____________________

**CURRENT MEDICATIONS:** (include prescriptions, over the counter, supplements, vitamins, and herbs)

| Name of Drug | Dose | Times Per Day | Reason | Prescribed By |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**ALLERGIES:**

| Source: (medications, pollens, food, animals, other) | Type of Reaction |
|---|---|
| | |
| | |
| | |

**SURGICAL HISTORY:** Please indicate with an **X** in the appropriate box if the following procedure is applicable to you.

| Surgical Procedure | X | Year | Surgical Procedure: | X | Year |
|---|---|---|---|---|---|
| Abdominal Surgery | | | Heart surgery | | |
| Appendectomy (Appendix) | | | Hernia Repair | | |
| Back Surgery | | | Hip Surgery | | |
| Biopsy | | | Hysterectomy | | |
| Breast Biopsy | | | Knee Surgery | | |
| Breast Surgery | | | LEEP (Cervix Surgery) | | |
| Colonoscopy | | | Ovary Removal | | |
| Coronary Bypass | | | Sigmoidoscopy | | |
| Coronary Stent | | | Sinus Surgery | | |
| Cosmetic Surgery | | | Tonsillectomy | | |
| EGD (Stomach Endoscopy) | | | Tubal Ligation | | |
| Cataract | | | Other: | | |
| Gallbladder Removal | | | Other: | | |

**FAMILY HISTORY:** Please indicate with an **X** if a family member has one of the following conditions:

| Condition | Mother | Father | Siblings | Grandparents |
|---|---|---|---|---|
| Cancer | | | | |
| Diabetes | | | | |
| Glaucoma | | | | |
| Heart Disease | | | | |
| High Blood Pressure | | | | |
| Mental Illness | | | | |
| Stroke | | | | |

Patient Name: ____________________________________________ Date of Birth: ___________________

## LIFESTYLE / SOCIAL HISTORY

**Do you smoke tobacco (*circle one*)?** **YES or NO**

If yes, about how many/day? _____________________

Do you feel you need to change this habit? YES or NO

**Do you drink alcohol (*circle one*)?** **YES or NO**

If yes, please answer the following questions:

Approximately, how many drinks per week? 0-3 3 or more

If 3 or more drinks per week, how many per day? 0-2 2-5 5 or more

What is your favored drink type? Beer Wine Liquor Other: _____________

Have you ever felt you should cut down on your drinking? YES or NO
Have people annoyed you by criticizing your drinking? YES or NO
Have you ever felt bad or guilty about your drinking? YES or NO
Have you ever taken a drink first thing in the morning to steady your nerves or get rid of a hangover? YES or NO

**Do you use other substances such as marijuana or other drugs (*circle one*)?** **YES or NO**

If yes, about how many times? Per week _______________ Per day _____________________

Please list substance(s) used: __________________________________________________________

**How many days in the last two weeks have you been bothered by the below symptoms?**

| | | | | |
|---|---|---|---|---|
| Little Interest, Pleasure in Activities | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |
| Feeling Down, Depressed, Hopeless | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |

*Please continue on to the following questions, if you chose an option other than "not at all" from the questions above. If you have chosen "not at all" to both questions, you may skip to the next section.*

**How many days in the last two weeks have you been bothered by the below symptoms?**

| | | | | |
|---|---|---|---|---|
| Trouble Falling or Staying Asleep | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |
| Feeling Tired or Little Energy | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |
| Difficulty Getting Along with Others | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |
| Thoughts about Hurting Yourself | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |
| Trouble Concentrating | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |
| Poor Appetite or Overeating | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |
| Feeling Bad about Yourself | ◯ Not at all | ◯ Several | ◯ Half or More | ◯ Nearly All |

Name: ___________________________________ Date of Birth: _______________ Todays Date: ________________

## DOMESTIC VIOLENCE SCREENING

Have you ever been physically or emotionally abused by a partner? ☐ YES ☐ NO

Have you been physically hurt by someone in the last year? ☐ YES ☐ NO

Within the last year has someone forced you to have sexual activity? ☐ YES ☐ NO

**If you have been diagnosed as having Diabetes, please let us know when your last testing was completed below.**

| Name of Test | Date Last Performed | Place Last Performed | If unknown, circle option: |
|---|---|---|---|
| Microalbumin | | | NOT SURE or NEVER |
| Hemoglobin A1C | | | NOT SURE or NEVER |
| Eye Exam | | | NOT SURE or NEVER |
| Foot Exam | | | NOT SURE or NEVER |

**IMMUNIZATIONS:** Please check off any vaccinations you have had, please add the approximate date if known.

| Vaccination: | Month /Year: | Vaccination: | Month /Year: |
|---|---|---|---|
| Flu Shot | | Pneumonia | |
| Hepatitis A | | Shingles | |
| Hepatitis B | | Tetanus | |
| HPV | | Tetanus w/Pertussis | |
| MMR | | Varicella (Chicken Pox) | |
| Meningitis | | Other: | |

**Have you had any of the following screening tests?**

| Screening test/Other test | Date | Location | Result (please circle) |
|---|---|---|---|
| Colonoscopy | | | Normal Abnormal |
| Dexa (Bone Density) Scan | | | Normal Abnormal |
| Mammogram | | | Normal Abnormal |
| Pap Smear | | | Normal Abnormal |
| Lipid Panel | | | Normal Abnormal |
| Aortic Aneurysm | | | Normal Abnormal |

## FUTURE PLANNING

Do you have an advance directive? YES or NO

If yes, does PSMC have a copy of it? YES or NO

*If no, please provide a copy to PSMC for our records.*

If you do not have an advance directive, do you wish to receive further information? YES or NO

Reviewed/Revised 11/29/2016, 6/21/2018, 11/3/2020