DRUID CITY FAMILY MEDICINE
701 Univ. Blvd., E., S-507, Tuscaloosa, AL 35401
Phone: (205) 330-3650 Fax: (205) 330-3655

NEW PATIENT (ADULT) HEALTH HISTORY

TODAY'S DATE: _____

Patient identification

Reason for today's visit: _____

What pharmacy do you want your prescriptions sent to?

_____

CURRENT MEDICATIONS (prescriptions AND over-the-counter)

Medication	Dose	Frequency	Who prescribed this medication?

Drug Allergies (please list your reaction to each drug): _____

_____

Food/latex/other allergies: _____

PAST MEDICAL HISTORY: (Please check any condition(s) that you have currently or have ever had in the past.)

- o Cataracts
- o Glaucoma
- o Recurrent sinusitis
- o Diabetes
- o Thyroid problems
- o Hay fever
- o Asthma
- o COPD
- o CPAP use
- o Sleep apnea
- o Abdominal aortic aneurysm
- o Angina
- o Afib/Atrial fibrillation
- o Irregular heartbeat
- o Heart disease
- o Deep vein thrombosis
- o Heart failure
- o Heart valve disease
- o High cholesterol
- o High blood pressure
- o Heart attack
- o Peripheral vascular disease
- o Colitis
- o Acid reflux
- o Irritable bowel syndrome (IBS)
- o Liver disease
- o Pancreatitis
- o Stomach ulcer
- o Sexually transmitted infection (STD)
- o Hemodialysis
- o Kidney disease
- o Kidney failure
- o Kidney stones
- o Peritoneal dialysis
- o Urinary incontinence
- o Benign prostatic hypertrophy (BPH)
- o Erectile dysfunction
- o Prostatitis
- o Testicular problems
- o Fibromyalgia
- o Fractures
- o Gout
- o Osteoarthritis
- o Osteoporosis
- o Rheumatoid arthritis
- o Anemia
- o Cancer (specify) _____
- o Leukemia or lymphoma
- o HIV/AIDS
- o Chicken pox
- o Hepatitis
- o Measles
- o MRSA infection
- o Polio
- o Positive PPD (test for TB exposure)
- o Rheumatic fever
- o Syphilis
- o Tuberculosis
- o Acne
- o Eczema
- o Psoriasis
- o ADHD
- o Autism
- o Dementia
- o Headaches
- o Multiple sclerosis
- o Parkinsons Disease
- o Peripheral neuropathy
- o Restless leg syndrome
- o Seizures
- o Stroke
- o TIA
- o Eating disorder
- o Anxiety
- o Bipolar disorder
- o Depression
- o Schizophrenia
- o Problems with alcohol
- o Substance abuse
- o Anaphylaxis (severe allergic reaction)
- o Motor vehicle accident
- o Hearing deficit
- o Vision deficit
- o Other _____
- o Other _____
- o Other _____
- o Other _____

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HOSPITALIZATIONS / SURGERIES / INJURIES:

Year	Name of illness/operation/injury

SPECIALISTS: What specialists do you see? (for example: cardiologist, dermatologist, eye doctor, etc.)

Name of Doctor/Practice	Specialty	Condition for which they treat you

FAMILY HISTORY: (Please check if any of your blood relatives have had any of the following:)

- o Alcoholism
- o Asthma
- o Atherosclerosis
- o Autoimmune disease
- o Blood disorder
- o Heart problem
- o Heart disease
- o Dementia
- o Depression
- o Diabetes mellitus
- o Drug abuse
- o Hearing problems
- o Hepatitis B
- o High cholesterol
- o High blood pressure
- o Kidney disease
- o Mental illness
- o Obesity
- o Rheumatoid disease
- o Stroke
- o Thyroid disease
- o Tuberculosis
- o Vision problems
- o Other _____

Relation	Current age or "D" if deceased	Health Problems/Cause of Death
Mother		
Father		

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HEALTH HABITS:

	Use daily	Use weekly	Use rarely	Do Not Use	Have used in past, but not now
Alcohol					
Caffeine					
Drugs					
Tobacco					
Herbal supplements					
Other					

Exercise (type and frequency): _____

Diet preferences or restrictions (e.g., gluten-free, vegan, etc.): _____

Spiritual beliefs/preferences: _____

HEALTH MAINTENANCE:

Up to date on childhood immunizations? ____ Yes ____ No

Year of last tetanus shot _____ (If you don't remember and you think it has been over 10 years check here): _____

Have you received Tdap as an adult? ____ Yes ____ No

Year of last flu vaccine _____

Year of last pneumovax (pneumonia vaccine), if applicable: _____

Have you had the shingles vaccine? ____ Yes ____ No

When was the last time your cholesterol was checked? _____

Date of last mammogram _____ Have you ever had an abnormal mammogram? ____ Yes ____ No

Date of last breast exam _____

Date of last pap smear _____ Have you ever had an abnormal pap smear? ____ Yes ____ No

Date of last bone density scan _____

Date of last colonoscopy _____

FOR WOMEN:

of pregnancies: _____ Do you desire to get pregnant? ____ Yes ____ No

# of births: _____ Age at first period? _____

children currently alive _____

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Please check all of the symptoms that you are currently experiencing or have had in the last 6 months.

CONSTITUTIONAL	o Appetite change o Excessive sweating o Fatigue	o Fever o Night sweats	o Weight gain ____ lbs o Weight loss ____ lbs
EYES	o Blurred vision o Wear glasses or contacts o Double vision	o Eye irritation o Eye pain	o Spots in vision o Vision loss
EARS, NOSE, MOUTH, THROAT	o Ear pain o Hearing loss o Ringing in ears o Facial pain o Runny nose	o Nasal obstruction o Nose bleeds o Post-nasal drainage o Bleeding gums	o Dental pain o Mouth lesions o Hoarseness o Sore throat
CARDIOVASCULAR	o Chest pain o Decreased exercise tolerance o Difficulty breathing with exertion	o Difficulty breathing when lying flat o Sleep on more than 1 pillow o Palpitations	o Fainting/passing out o Leg pain with walking o Leg ulcers o Swollen feet/ankles
RESPIRATORY	o Cough o Sputum (phlegm) production o Coughing up blood	o Shortness of breath o Chest pain with deep breathing	o Wheezing o Snoring o Sleep apnea
GASTROINTESTINAL	o Abdominal pain o Bloating o Food intolerance (explain): _____	o Nausea o Vomiting o Trouble swallowing o Reflux/heartburn	o Change in bowel habits o Constipation o Diarrhea o Black stools o Bloody stools
GENITOURINARY	o Change in urinary stream o Pain with urinating o Blood in urine o Incontinence o Awakening at night to urinate	o Frequent urination o Feel the urge to urinate o Penile discharge o Impotence/sexual dysfunction o Painful menstrual cramps	o Pain with sexual intercourse o Post-menopausal o Vaginal discharge o Vaginal itching o Frequent UTIs
MUSCULOSKELETAL	o Back pain o Joint pain o Joint swelling	o Limited range of motion o Muscle aches o Muscle weakness	o Stiffness
INTEGUMENTARY	o Recent change in hair or nails o Recent changes in oiliness or dryness of skin o Lesions	o Changes in moles o Pigment changes o Itching o Rash	o Breast masses o Breast skin changes o Nipple discharge
NEUROLOGIC	o Abnormal gait o Weakness of a particular body part (not overall weakness) o Headache	o Incoordination o Memory problems o Numbness o Seizures	o Slurred speech o Tremor o Dizziness or vertigo
PSYCHIATRIC	o Anxiety o Decreased concentration	o Irritability o Panic attacks	o Sleep disturbances o Sadness/tearfulness
ENDOCRINE	o Increased thirst o Increased appetite	o Urinating frequently and large amount	o Hot-natured o Cold-natured o Abnormal menstrual pattern
HEMATOLOGIC/LYMPHATIC	o Easy bruising o Easy bleeding	o Recurrent infections o Swollen lymph nodes	
ALLERGIC/IMMUNOLOGIC	o Eczema	o Seasonal allergies	o Hives