Oakstone HEALTH CENTER

NEW PATIENT: ADULT

Name_____ Date of Birth_____ Age _____
Address_____ City_____ Zip _____
Phone_____ Occupation/ Employer _____
1. Please list any medication to which you are allergic or which you are unable to take for any reason._____
2. Please list any medication, either prescription or over the counter (birth control pills, aspirin, etc.) that you are taking on a regular basis._____
_____
3. Please list all of your surgeries (tonsillectomy, appendectomy, etc.)

Year	Surgery	Reason	Surgeon

4. Please list any serious illnesses that you have had in the past or have now (diabetes, blood pressure trouble, etc.).

Year of Onset	Illness	Condition at Present

Preventive Health Care Information

1. Date of most recent chest x-ray_____ EKG_____ PAP Test_____
Were they all normal? Yes ☐ No ☐
Explain_____
2. Date of most recent tetanus immunization_____
3. Have you ever had mumps? Yes ☐ No ☐ or date of mumps vaccine_____
4. Have you ever had rubella (3-day measles)? Yes ☐ No ☐ or date of rubella vaccine
Ht._____ Wt. _____

Personal History

1. Marital Status: Single____ Yr. Married_____ Yr. Separated_____ Yr. Divorced _____ Yr. Widowed _____
Have you been married more than once? Yes ☐ No ☐
Age of children from this marriage (if any)_____
Age of children from previous marriage (if any)_____
2. Education (highest grade or degree achieved)_____

FAMILY HISTORY

Mark those diseases you have had. If *you know other members* of *the family with these diseases, please mark this also. (X) = Patient*
(M)= *Mother* (F) = *Father (SP) = Spouse.*
(R)=*Blood Relative (BIS)=Brother or Sister*

x	M	F	R	B/S	SP	
☐	☐	☐	☐		☐	Allergies
☐	☐	☐	☐		☐	Hay Fever
☐	☐	☐	☐		☐	Skin Problems
☐	☐	☐	☐		☐	Glaucoma
☐	☐	☐	☐		☐	High Blood Pressure
☐	☐	☐	☐		☐	Stroke
☐	☐	☐	☐		☐	Coronary Heart Disease
☐	☐	☐	☐		☐	Other Heart Disease
☐	☐	☐	☐		☐	Emphysema
☐	☐	☐	☐		☐	Asthma
☐	☐	☐	☐		☐	Yellow Jaundice
☐	☐	☐	☐		☐	Gall Bladder Trouble
☐	☐	☐	☐		☐	Kidney Problems
☐	☐	☐	☐		☐	Diabetes
☐	☐	☐	☐		☐	Gout
☐	☐	☐	☐		☐	Thyroid Disease
☐	☐	☐	☐		☐	Mental Retardation
☐	☐	☐	☐		☐	Mental Illness
☐	☐	☐	☐		☐	Muscular Dystrophy
☐	☐	☐	☐		☐	Bleeding Tendency
☐	☐	☐	☐		☐	Blood Disorder
☐	☐	☐	☐		☐	Leukemia
☐	☐	☐	☐		☐	Arthritis
☐	☐	☐	☐		☐	Other Joint Problems
☐	☐	☐	☐		☐	Cancer

Family	**Current Health** **Good** **Poor**	**Cause of Death**	**Age at Death**
Father:			
Mother:			
Siblings:			

RISK ASSESSMENT

1 . Exposure
Mark those to which you have frequently been exposed.

☐ Chemicals, cleaning fluids, oils
☐ Loud noise
☐ Asbestos or cement dust
☐ X-rays or radioactive materials

2. Alcohol
☐ never drink alcohol
☐ 3-4 times yearly
☐ Once a week
☐ 2-3 times per week
☐ Drink daily
☐ Drink excessively
☐ Beer ☐ wine liquor
☐ Have quit drinking alcohol.
Specify time length _____

3. Drug Use
Do you use marijuana or recreational drugs? ☐ Yes ☐ No
Have you ever used needles to inject drugs? ☐ Yes ☐ No

3. Tobacco
☐ Never use tobacco cigarettes

- [?] Less than 1 pack per day
- [?] 1-2 packs per day
- [?] 2-3 packs per day
- [?] Over 3 packs per day _____

How many years? _____

Other
- [?] smoke cigars
- [?] smoke pipe
- [?] I quit using tobacco.

Specify time length _____

4. Cups of Coffee per day

Comments:_____
_____

Name_____ Appointment Date_____

The following questionnaire is used to obtain a survey of your past and present medical history. Please check the statements that apply to you and circle any that you do not understand or may have questions about. Thank you!

I. GENERAL

- [?] Recent loss in weight
- [?] Swelling of any part of your body
- [?] Any growth, tumor, unusual mole or wart
- [?] Unexplained fever
- [?] Ulcers, skin rash, or cuts that will not heal
- [?] Chronically tired and fatigued
- [?] Difficulty in sleeping
- [?] Recent change in appetite
- [?] Drink water excessively
- [?] A recent injury
- [?] Been denied or up-rated on life insurance
- [?] Been rejected or discharged from the military for medical reasons

II. SPECIAL SENSES

- [?] Any blurred or double vision
- [?] Vision getting worse
- [?] Wear glasses
- [?] Any ringing in your ears
- [?] Hearing impaired
- [?] A change in your taste or smell
- [?] Your nose chronically “stopped up”
- [?] Frequent sore throats or colds
- [?] Any hoarseness of your voice

III. **SPECIAL SENSES**

- [?] Unexplained stomach trouble

IV. GENITO-URINARY

- [?] Bloody Urine
- [?] Is your urine cloudy
- [?] Do you have to urinate frequently
- [?] Do you have the desire to urinate frequently
- [?] Do you have painful urination
- [?] Urinate frequently at night
- [?] Back pain

MALES ONLY

- [?] Do you have ulcer or sores on your penis
- [?] Any swelling of the testicle
- [?] Do you have a problem obtaining or maintaining an erection

V. CARDIOVASCULAR & RESPIRATORY

- [?] Rapid beating of your heart
- [?] Swelling of ankles or feet
- [?] Shortness of breath
- [?] Swelling of your abdomen
- [?] Pain in your chest
- [?] Pain and/or numbness of your arms
- [?] Pain in your legs while walking
- [?] Coldness or skin color changes of feet or hands
- [?] Sensitive to cold temperatures
- [?] Tightness in your chest
- [?] Do you have asthma

- [?] Indigestion
- [?] Nausea and/or vomiting
- [?] Vomiting blood
- [?] Jaundice
- [?] Intolerance to fatty acids
- [?] Allergy to any food
- [?] Unexplained abdominal pain or distress
- [?] Change in bowel movement habits
- [?] Change in color of bowel movements
- [?] Presence of blood in your stool
- [?] Painful bowel movements
- [?] Presence of hemorrhoids or rectal itching
- [?] Diarrhea or constipation
- [?] Ever had a pilonidal cyst

VI. MUSCULOSKELETAL

- [?] Have you had a dislocation or fracture
- [?] Pain or stiffness in any joints of your body
- [?] Any back pain
- [?] Decrease in the size of any muscles
- [?] Weakness of any part of your body
- [?] Wear a brace of any type
- [?] Bursitis
- [?] Arthritis
- [?] Had a “Trick Joint” (knee, shoulder, etc)

VII. NERVOUS AND MENTAL

- [?] Had frequent or severe headaches
- [?] Dizziness, lightheadedness
- [?] Fainting or blacking out spells
- [?] Difficulty in walking
- [?] Weakness of hands
- [?] Muscles “quiver”
- [?] Difficulty in eating or swallowing
- [?] Difficulty in talking
- [?] Tremors or shaking of any part of your body
- [?] Excessive salvation
- [?] Difficulty in keeping your eyes open
- [?] Tire easily
- [?] Numbness or “Pins & Needles” of any part of your body
- [?] Nervous or anxious

_____

- [?] Depressed or feeling blue
- [?] Difficulty thinking
- [?] Memory poor or loss of memory
- [?] Chronic cough
- [?] Have you coughed up blood or
- [?] Had high or low blood pressure
- [?] Wheezing type of breathing
- [?] Have you had Rheumatic Fever
- [?] Bled excessively after an injury or tooth extraction

VIII. FEMALES ONLY

- [?] Problems with sexual arousal or
- [?] Have you been or are you pregnant
- [?] Had a vaginal discharge
- [?] Been treated for female problems
- [?] Had a painful menstruation
- [?] Had irregular menstruation

COMPLETE THE FOLLOWING:

_____ Age of onset of periods
_____ Interval between periods
_____ Duration of periods
_____ Quantity- Normal, excessive, scanty
_____ Date of last period
_____ Number of pregnancies
_____ Number of live births
_____ Number of miscarriages

IX. LIST ILLNESSES REQUIRING HOSPITALIZATION OR PROLONGED OR EXTENSIVE TREATMENT

(Date & Treatment, if known)

_____
_____
_____
_____
_____

- [ ] Difficulty in relaxing

_____

- [ ] Having “problems”
- [ ] Become angry easily
- [ ] Vague fears
- [ ] Difficulty at home or at work

_____

- [ ] Any material or sexual concerns

_____
_____
_____
_____