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Integrated Health Care

PRIMARY CARE
ADULT PATIENT HEALTH HISTORY

Patient's Name:	**Birthdate:**	**Age:**	**Male / Female**
Current Medical Provider:	Reason for transferring care:		
Preferred Pharmacy:			

CURRENT HEALTH			
Present Health Concerns:			
MEDICATIONS: Please list ALL medications including vitamins, herbs, home remedies			
Medication Name	Strength (mg)	Directions	Reason Taking
Aspirin ☐ Yes ☐ No			
Verified by (Adapt staff initial):			

ALLERGIES: or reactions to medications, environmental, animals, food, vaccines, etc.	
Allergy	Symptoms or Reaction
Verified by (Adapt staff initial):	

HEALTH SCREENING QUESTINNAIRE
Do you now or have you ever used tobacco? ☐ Current ☐ Previous ☐ Never
How many times in the past year have you had 4 or more drinks in a day? ☐ None ☐ 1 or more

One Drink =  **12 oz. beer**  **5 oz. wine**  **1.5 oz. liquor (1 shot)**

Do you sometimes use drugs recreationally, including marijuana or prescription drugs? ☐ No ☐ Yes
In the last 2 weeks have you been bothered by:
a) Little interest or pleasure in doing things? ☐ No ☐ Yes
b) Feeling down, depressed or hopeless? ☐ No ☐ Yes

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Patient's Name: **Date of Birth:**

MEDICAL HISTORY (Please indicate with an **X** all that apply)

- ☐ Brain Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Ovarian Cancer
- ☐ Pancreatic Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Tumor (benign)
- ☐ Tumor (malignant)
- ☐ Other Cancer: _____
- ☐ CHF
- ☐ DVT
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ MI (Heart Attack)
- ☐ Stroke
- ☐ Atrial Fibrillation
- ☐ Eye Disease
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Otitis Media (ear infections)
- ☐ Cataracts
- ☐ Dysplastic Moles
- ☐ Arthritis
- ☐ Chronic Back Pain
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Autoimmune Disorder
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Endocrine Issues
- ☐ Hyperthyroidism (high)
- ☐ Hypothyroidism (low)
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ TB (Tuberculosis)
- ☐ Chronic Headaches
- ☐ Epilepsy
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Seizure Disorder
- ☐ Anxiety Disorder
- ☐ Bipolar
- ☐ Dementia
- ☐ Depression
- ☐ Development Disorder
- ☐ Psychiatric Illness
- ☐ Substance Abuse
- ☐ Suicide Attempt
- ☐ Other:
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ GERD
- ☐ GI Bleed
- ☐ Hepatitis_____
- ☐ Liver Disease
- ☐ Ulcer
- ☐ Ulcerative Colitis
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Urinary Disorder
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Transfusions
- ☐ Clotting Disorders
- ☐ Peripheral Vascular
- ☐ MRSA

SURGICAL HISTORY (Please indicate with an **X** all that apply)

- ☐ Hernia Repair
- ☐ Gallbladder Removed
- ☐ Gastric Surgery
- ☐ Small Bowel Resection
- ☐ Colon Resection
- ☐ Appendix Removed
- ☐ Breast Lumpectomy
- ☐ Mastectomy
- ☐ Breast Augmentation
- ☐ Coronary Artery Bypass
- ☐ Coronary Artery Stenting
- ☐ Heart Valve Surgery
- ☐ Craniotomy
- ☐ Other
- ☐ Peripheral Vascular Bypass
- ☐ Peripheral Vascular Stenting
- ☐ Aneurysm Repair
- ☐ Carotid Surgery
- ☐ Vein Surgery
- ☐ Lung Surgery
- ☐ Esophageal Surgery
- ☐ Bunion Surgery
- ☐ Hammer Toe Correction
- ☐ Repair Up Extremity Fracture
- ☐ Repair Low Extremity Fracture
- ☐ Arthroscopy
- ☐ Rotator Cuff Repair R / L
- ☐ ACL Repair
- ☐ Total Hip Replacement R / L
- ☐ Total Knee Replacement R / L
- ☐ Total Shoulder Replacement
- ☐ Carpal Tunnel Surgery R / L
- ☐ Prostate Surgery- Cancer
- ☐ Prostate Surgery for BPH
- ☐ Incontinence Surgery
- ☐ Kidney Removed
- ☐ Bladder Surgery
- ☐ Tonsillectomy
- ☐ Ear Tube Placement
- ☐ Hysterectomy
- ☐ Ovary Removed R / L
- ☐ C-Section
- ☐ Laparoscopy
- ☐ Bladder Suspension
- ☐ Cervical Surgery
- ☐ Lumbar Surgery
- ☐ Thoracic Spine Surgery
- ☐ Cataract Surgery
- ☐ Eyelid Surgery
- ☐ Sex Reassignment M to F
- ☐ Sex Reassignment F to M

SOCIAL HISTORY

Occupation:	Where Employed:	Education Level:
Lives With:	Marital Status:	Spouse's Name:
# of Children:	Nickname:	Religion:

Primary Language: ☐ English ☐ Spanish ☐ Other (specify):

Gender/ Gender Preference *(please check one)* ☐ Male ☐ Female ☐ Other ☐ Choose to disclose
☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female

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Patient Name: **Date of Birth:**

FAMILY HEALTH HISTORY

Please indicate with an X family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Mom's Sister	Mom's Brother	Dad's Mom	Dad's Dad	Dad's Sister	Dad's Brother
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Angina	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cervical Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Coronary Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Growth / Development Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung / Respiratory Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Melanoma / Skin Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Severe Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Weight Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Medical Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
No / Unknown Family History	☐											

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Patient Name:	**Date of Birth:**

TOBACCO USE

Current Tobacco Use: ☐ Never ☐ Former ☐ Current How much per day:

Type of Tobacco Use: ☐ Cigarette ☐ Cigar ☐ Smokeless (chew) ☐ Vape ☐ Pipe

Have you tried to quit? ☐ No ☐ Yes Method attempted: Passive smoke exposure? ☐ No ☐ Yes

ALCOHOL USE

Current Alcohol Use: ☐ Never ☐ Former ☐ Current Average # drinks per day: Type of alcohol:

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the Past

SUBSTANCE USE

Do You Use: ☐ None ☐ Methamphetamine ☐ Cannabis/Marijuana ☐ Inhalants ☐ Tranquilizers/benzodiazepines ☐ Cocaine ☐ Narcotics (opiates/narcotics/heroin) ☐ Hallucinogens ☐ Other

How often used? ☐ Daily ☐ Weekly ☐ Monthly

Reason for Use:

OTHER

Current Caffeine Use: ☐ Yes ☐ No Type: ☐ Coffee ☐ Soda ☐ Energy Drinks ☐ Other:

Exercise Routinely? ☐ Yes ☐ No How many times per week? Type of Exercise:

Vehicle Seatbelt Use: ☐ 100% of time ☐ 50% of time ☐ 25% of time ☐ Never

Sunshine Exposure: ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Do you use sunscreen? ☐ Yes ☐ No

Do you believe that you are at high risk for HIV? ☐ Yes ☐ No If yes, explain:

PREVENTATIVE CARE SCREENINGS

Please place an X next to each test and provide approximate date, results and place where it was done.

☐ Pap Smear Date: Results: ☐ Normal ☐ Abnormal Place:

☐ Colon Screening Date: Type: ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Stool Hemoccult
Results: ☐ Normal ☐ Abnormal ☐ # of polyps removed Place:

☐ Breast Screening Date: Results: ☐ Normal ☐ Abnormal Place:

☐ Dexa Scan (bone density) Date: Results: ☐ Normal ☐ Abnormal Place:

☐ PSA (prostate level) Date: Results: ☐ Normal ☐ Abnormal Place:

Please bring immunization/vaccine history information to your first appointment.

WOMEN'S HEALTH

Are you now or are you planning to become pregnant in the next year?
☐ Currently Pregnant ☐ Not planning to become pregnant in next year ☐ Planning to become pregnant

Please place and X next to each option that applies.

☐ Hysterectomy	☐ Depa-DMPA Date of last shot:
☐ Bilateral Tubal Ligation Date:	☐ Condoms
☐ Hysteroscopic tubal Occlusion Date:	☐ Rhythm Method
☐ Implant/Nexplanon Date:	☐ Abstinence
☐ IUD Type: ☐ Mirena ☐ Paragard ☐ Skyla Date:	☐ Menopause Natural Date:
☐ Diaphragm	☐ Menopause Surgical Date:
☐ Oral/Hormonal contraceptives ☐ Oral ☐ Patch ☐ Ring	☐ Vasectomy
Age Menses Started: Age Menopause Started:	Are you sexually active? ☐ Yes ☐ No

PREGNANCY HISTORY			
Total Pregnancies:	Deliveries:	Abortions:	Miscarriages:
ADVANCED DIRECTIVES IN PLACE			
☐ None	☐ Living Will	☐ Durable Power of Attorney	☐ Health Care Proxy	☐ POLST

**********FOR OFFICE USE ONLY**********

Reviewed by Provider:_____ Date: _____

Records Requested for screening by: _____ Date: _____