Facey Medical Group

With Providence

EMR #: ____________

Adult Patient Health History

Date: ____________ Date of Birth (mm/dd/yyyy): ____/____/______

Patient Name: ______________________ Relationship Status: ☐ Single ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed

Age: ________ Height: ________ Occupation: ______________________

Your Current Health

Please list your primary health concerns right now: ______________________

Current Medications & Vitamins: ☐ None ☐ Yes ➔ list with dosages: ______________________

Known Allergies: ☐ None ☐ Yes ➔ list: ______________________

Health History

	Yes	No	Unsure		Yes	No	Unsure		Yes	No	Unsure
Measles				Mumps				Migraine Headaches			
Rubella				Rheumatic Fever				Chicken Pox			
Mononucleosis				Meningitis				Hernia			
Pneumonia				Diabetes				Syphilis			
Emphysema				Thyroid Disease				Other STI's			
Asthma				Arthritis				Broken Bones			
Bronchitis				Gout				Nervous Breakdown			
Kidney Stone				Cancer (type:)				Suicide Attempt			
Kidney Infection				Colitis				Depression (requiring meds)			
Ulcers				Diverticulitis				Drug/Alcohol Abuse			
Hepatitis				Irritable/Spastic Bowel				Major Head Injury			
Liver Disease				Heart Attack				Transfusions			
Gallbladder Disease				Heart Murmur				Other Major Illnesses/Injuries (*if yes, please list below*)			
AIDS				Stroke							
Bleeding Tendencies				High Blood Pressure							
Tuberculosis				Heart Problems							
Positive TB Test				Epilepsy / Seizures							

Surgeries ☐ None ☐ Yes ➔ List type & year

Hospitalizations ☐ None ☐ Yes ➔ List type & year

Men's Health

	Yes	No	Unsure		Yes	No	Unsure		Yes	No	Unsure
Enlarged Prostate				Prostate Infection				Epididymitis			
Testicle Problem(s)				Urine Infections				Other (list)			

Women's Health

	Yes	No	Unsure		Yes	No	Unsure		Yes	No	Unsure
Abnormal PAP				Benign Breast Lump				Ovarian Cysts			
Uterine Fibroids				Pelvic Infections				Urine Infections			
PMS				Painful Periods				Contraception (type) -			
Age at First Period:				Are your periods regular?				Date of Last Period -			

Pregnancies? ☐ None ☐ Yes ➔ How many? Deliveries: ☐ None ☐ Yes ➔ How many? Miscarriages: ☐ None ☐ Yes ➔ How many?

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Adult Patient Health History

Past Exams

	Yes- Date	No	Unsure		Yes- Date	No	Unsure		Yes- Date	No	Unsure
Wellness/Physical				Stool Hematest				Mammogram			
PAP Test (f only)				Sigmoidoscopy				Tuberculosis			
Other tests we should know about:											

Vaccinations

	Yes- Date	No	Unsure		Yes- Date	No	Unsure		Yes- Date	No	Unsure	Other	Date
Tetanus				Flu/Influenza				Pneumonia					
Measles				Rubella				Polio					
Tuberculosis (BCG)				Hepatitis				HPV					

Family History

	If living, list age & health	If deceased, please list age at death & cause
Father's Father:		
Father's Mother:		
Mother's Father:		
Mother's Mother:		
Father:		
Mother:		
Brother(s):		
Sister(s):		
Son(s):		
Daughter(s):		
Spouse (if applicable):		

Have any of your blood relatives had any of the following illnesses?

	Yes	No	If Yes, Who?
Heart Attack			
Heart Disease			
High Blood Pressure			
Stroke			
Breast Cancer			
Cancer			
if yes, list type(s):			
Insulin Diabetes			
Non-Insulin Diabetes			
Sickle Cell Disease			
Asthma			
Tuberculosis			
Thyroid Disease			
Behavioral Health Issues			
Alcohol/Drug Abuse			
Migraine Headaches			
Bleeding Tendencies			
Other:			

Health-Related Behaviors

Do you drink caffeinated beverages? ☐ No ☐ Yes → How many drinks do you typically consume in a day? ________

Do you drink alcohol? ☐ No ☐ Yes → Please list how many drinks you typically consume in a week:

Glasses of Wine: ________ Beer (12 ounces): ________ Shots: ________ Drinks with .5oz of alcohol: ________

Have you ever had a drinking problem? ☐ No ☐ Yes → Please explain: ________

Do you use recreational drugs? ☐ No ☐ Yes → Please list, with frequency: ________

Do you currently smoke tobacco? ☐ No → Have you ever regularly smoked tobacco? ☐ No ☐ Yes → Year you quit smoking: ________

☐ Yes → How many packs per day? ________ Tobacco type: ☐ Cigars ☐ Cigarettes ☐ Pipe

Do you exercise regularly? ☐ No ☐ Yes → What activities and how often? ________

Do you wear seat belts? ☐ No ☐ Yes, always ☐ Yes, sometimes

Are you sexually active? ☐ No ☐ Yes Sexual Preference: ☐ Men ☐ Women ☐ Men & Women # of sexual partners in the last year: ________

Please return completed form to a member of our reception team. Thank you.

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