Dayspring Family Health Center

INITIAL ADULT HISTORY – Patient to complete at Initial Visit

Patient Name: **Date of Birth:**

Have you ever had:	Surgeries you've had:	Have your parents or siblings ever had:	Concerns you've had about your health in the past 6 months:
___ High blood pressure	___ Appendix	___ High blood pressure	___ Chest pain
___ Heart disease	___ Gallbladder	___ Heart disease	___ Cough
___ Asthma	___ Tonsils/adenoids removed	___ Cholesterol disorder	___ Shortness of Breath/wheeze
___ Diabetes (sugar)	___ Heart Bypass	___ Diabetes (sugar)	___ Swelling
___ High Cholesterol	___ Heart balloon/stent	___ Blood clots in the veins	___ Loss of Energy
___ Thyroid disease	___ Joint replacement	___ Asthma	___ Frequent urination
___ Depression /Anxiety	___ Back surgery	___ Thyroid	___ Change of bowel movements
___ Kidney Stones/Problem	___ Hysterectomy	___ Alcoholism	___ Blood in stool
___ Seizure disorder	___ Tubes Tied	___ Drug Abuse	___ Weight gain/ loss
___ Hepatitis	___ Vasectomy	___ Depression	___ Non-healing sore
___ Stroke	___ Cesarean Section	___ Bipolar Disease	___ Change in mole
___ Blood clots in the veins	___ D&C for miscarriage	___ Cancer	___ Neck or Back Pain
___ Headaches; migraine	___	___ colon	___ Nervousness/Depression
___ Anemia (low blood)		___ breast	___
___ Cancer		___ melanoma	

Social History:

- I am… single married divorced widowed living with my partner
- Do you feel threatened by anyone you live with? NO YES - _____

Occupation:

- unemployed disabled work as _____

Religion:

- Do you attend a house of worship? NO YES - _____

Tobacco:

- Do you smoke cigarettes? NO YES - _____ packs/ day

Alcohol:

- How often do you drink alcohol? Never Occasionally Weekends Daily

Drugs:

- In the past year, have you used any drugs? NO YES - _____

Advanced Directives

- Do you have a living will? NO YES
- Do you have a power of attorney? NO YES - _____
- Do you have a code status NO YES - _____

Special Communication Needs

- Do you have difficulty ... Hearing? Seeing? Reading?
- Do you have difficulty understanding English? NO YES

Safety History:

- Do you wear a seatbelt in your car? Yes No
- Do you have a smoke detector at home? Yes No
- Have you fallen in the past 6 months? Yes No
- Do you have problems with vision? Yes No
- Do you have problems hearing? Yes No

Vaccine History:

When did you last receive…

Tetanus Vaccine? _____ Never

Pneumonia Vaccine? _____ Never

Influenza Vaccine? _____ Never

Pregnancy History:

How many times have you been pregnant? _____

How many live children? _____

How many miscarriages have you had? _____

Have you had any abortions? _____

How many c-sections? _____

- Over the past 2 weeks, how often have you …
  - -felt down, depressed, or hopeless? Not at all (0) Several days (1) Half the time (2) Nearly every day (3)
  - - had little interest/pleasure in doing things? Not at all (0) Several days (1) Half the time (2) Nearly every day (3)

Medical Provider Signature: _____ **Date:** _____