UT★Physicians

(Nurse/MA to complete: Ht: _____ Wt: _____ BP: _____ P: _____ Temp: _____ R: _____)

ESTABLISHED PATIENT ADULT HEALTH HISTORY FAMILY MEDICINE

Patient Name:_____ Date: _____

Reason for Visit: _____

Any recent visits to the ER? ☐ No ☐ Yes, location and date of visit: _____

Hospital or other Doctor visits? ☐ No ☐ Yes, location: _____

Any new health problems since your last visit? ☐ No ☐ Yes, describe: _____

_____

Pharmacy Name: _____ Pharmacy #: _____

SOCIAL HISTORY

Tobacco use:	Never _____ Interested in Quitting: ☐ Yes ☐ No E-cigarette ☐ Yes ☐ No Cigarettes: Pks/day _____ #years: ____ Quit date: _____ Other tobacco: ☐Pipe ☐Snuff ☐Chew ☐Cigars Secondhand Smoke Exposure: ☐ Yes ☐ No	**Caffeine Intake:**	None _____ Yes: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink #cups per day _____
Alcohol use:	How many times in the past year have you consumed more than 4 drinks in one sitting? _____ Is your alcohol use a concern for you or others? ☐ Yes ☐ No	**Weight:**	Are you satisfied with your weight? ☐ Yes ☐ No
Recreational Drug Use:	Do you use or have ever used any recreational drugs (Marijuana, cocaine, or heroin)? ☐ Yes ☐ No Do you use or have ever used any synthetic cannabinoids (dried chemicals)? ☐ Yes ☐ No Have you ever used needles to inject recreational drugs? ☐ Yes ☐ No Have you ever taken drugs through your nose? ☐ Yes ☐ No	**Diet:**	How do you rate your diet? ☐ Good ☐ Fair ☐ Poor Do you eat or drink 4 servings of dairy or soy daily? ☐ Yes ☐ No Do you take calcium supplements? ☐ Yes ☐ No Do you take vitamin D supplements? ☐ Yes ☐ No Do you exercise regularly? ☐ Yes ☐ No How long? _____ minutes #times per week? _____ If no exercise, why? _____
Sexual Activity:	Are you sexually active? ☐ Yes ☐ No Current sex partner(s) is:☐ Male ☐ Female Birth Control Method: _____ Have you ever had any sexually transmitted diseases? ☐ Yes ☐ No	**Other:**	Have you completed any of the following: Living Will ☐ Yes ☐ No Durable Power of Attorney ☐ Yes ☐ No Medical Power of Attorney ☐ Yes ☐ No If yes, please provide us with a copy

SOCIAL ECONOMICS

Occupation/Employer _____

Year of Education Completed _____

Highest Degree _____

Who lives at home with you? _____

Spouse or Partner's Name _____

(Nurse/MA to complete: Ht: _____ Wt: _____ BP: _____ P: _____ Temp: _____ R: _____)

CHANGES IN MEDICATIONS

Are there any changes in your medications from your last visit? ☐ No ☐ Yes, please list below:

Do you have any food or drug allergies? ☐ No ☐ Yes, If yes, please list reaction: (example: nausea, rash, hives, abnormal lab test):

_____

Current Medications: Please include prescribed, over the counter, birth control pills, supplements, vitamins, herbs (if more space is needed, see last page):

Name	Dosage (how much)	How often	How is it taken
1.			☐ Mouth ☐ Cream ☐ Other
2.			☐ Mouth ☐ Cream ☐ Other
3.			☐ Mouth ☐ Cream ☐ Other
4.			☐ Mouth ☐ Cream ☐ Other
5.			☐ Mouth ☐ Cream ☐ Other
6.			☐ Mouth ☐ Cream ☐ Other
7.			☐ Mouth ☐ Cream ☐ Other
8.			☐ Mouth ☐ Cream ☐ Other
9.			☐ Mouth ☐ Cream ☐ Other
10.			☐ Mouth ☐ Cream ☐ Other