UT★Physicians

NEW PATIENT ADULT HEALTH HISTORY FAMILY MEDICINE

Patient Name:_____ **Date**: _____

Date of Birth: _____ MRN (office use only): _____

Language preference: ☐English ☐Spanish ☐Vietnamese ☐Other:_____

Main reason/concern for your visit today: _____

Are you seeing other physicians? ☐ No ☐ Yes Name: _____ Phone #: _____
(Additional physicians may be added to last page)
Date and Description of last laboratory tests: Date:_____ Description: _____
Recent emergency room and/or hospital visit? ☐ No ☐ Yes, date: _____ location: _____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

PERSONAL MEDICAL PROBLEMS

Please check if you are having any of the following medical problems

☐ Lung Problems	☐ Kidney Problems	☐ Diabetes	☐ Asthma	☐ Liver Disease
☐ Heart Problems	☐ Hypertension	☐ Bleeding Problems	☐ Gastritis/Reflux	☐ Osteoporosis
☐ Heart Disease	☐ High Cholesterol	☐ Thyroid Problems	☐ Cancer	☐ Colon Polyps
☐ Depression/Anxiety	☐ Blood Disorder	☐ Seizure Disorders	☐ Vision/Glasses	☐ Hearing Problems

Other _____

How would you rate your general health? ☐Excellent ☐Good ☐Fair ☐Poor

History of falls ☐ No ☐ Yes

Did the fall result in an injury ☐ Yes ☐ No Use of cane/walker/wheelchair? ☐ Yes ☐ No

SURGICAL HISTORY

Please list all prior operations below (with dates) (if more space is needed, see last page):

_____

_____

FAMILY HISTORY

Do your parents, sibling, and children have any of the current health conditions:

	Parent	Sibling	Children		Parent	Sibling	Children
Alcohol/Drug Abuse				High cholesterol			
Cancer (type)				High blood pressure			
Depression/Suicide				Stroke			
Genetic disorders				Bleeding or clotting disorder			
Diabetes				Asthma/COPD			
Sudden death				Birth defects			
Other:							

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SOCIAL ECONOMICS

Work status	Occupation: _____ ☐ Full Time ☐ Part Time ☐ Unemployed ☐Disability ☐ Retired ☐ Student ☐ Other: _____
Education completed	☐ None ☐ Elementary School ☐ Middle School ☐ High School/GED ☐ Some College ☐ Bachelors ☐ Masters ☐ Advanced Graduate/Ph.D. ☐ Other: _____
Who lives at home with you?	
Spouse or Partner's name	
Exposure to work or home hazards?	☐ Yes ☐ No
Living situation	☐ Home/Independent ☐ Home w/assistance ☐ Homeless/Shelter ☐ Other: _____
Current needs unmet	☐ None ☐ Food ☐ Clothing ☐ Utilities ☐ Rent/Mortgage payment ☐ Transportation ☐ Child Care ☐ Medicine/Medical Care ☐ Phone ☐ Other: _____

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 4 drinks or more 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 & Wellness:**	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
Home Life:	Please check if you do the following: ☐ Drive ☐ Cook ☐ Grocery Shop ☐ Bathe Yourself ☐ Manage your Finances Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? ☐ No ☐ Yes, by whom? _____ Do you feel safe in your current and past personal relationships? ☐ Yes ☐ No Do you feel safe in your current work environment? ☐ Yes ☐ No Do you feel safe in your current home environment? ☐ Yes ☐ No		

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CURRENT MEDICATIONS

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

IMMUNIZATIONS/VACCINES

Please enter date(s) of immunizations below

Hepatitis A: _____	Influenza (Flu) : _____	MMR: _____
Hepatitis B: _____	Pneumonia: _____	Meningitis: _____
Varicella/Chicken Pox: _____	Tdap (tetanus, diphtheria & pertussis): _____	
Did you have the chicken pox infection? ☐ No ☐ Yes If yes, what year? _____		
HPV (genital warts):_____	Shingles:_____	Td (tetanus) : _____
Other: _____		

HEALTH MAINTENANCE Have you had any of the following screens or tests performed? If yes, please enter date of test and result of that test. Circle N if the results were normal and A if abnormal.

Mammogram: _____ N/A *Location of test:* _____		Lipids: _____
Stool-blood test: _____	Colonoscopy: _____ N/A *Location of test:* _____	
Bone density scan: _____	HIV test: _____	Foot exam: _____
Sigmoidoscopy: _____ N/A	Dental Exam: _____	PSA test (male): _____
PAP Smear: _____ N/A	Eye Exam: _____	Hb A1c: _____

Do you need a Return to Work/School Note? ☐Yes ☐No

_____ _____

Physician Name **Physician Signature** **Date**

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(Continued from previous sections)

Other Physicians:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

More Surgical History:

_____

_____

_____

More Current Medication:

Name	Dosage (how much)	How often	How is it taken
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
11.			☐ Mouth ☐ Cream ☐ Other
12.			☐ Mouth ☐ Cream ☐ Other