**ADULT BASELINE HISTORY FORM** **www.familywellnesscntr.com**

**NAME ______________________ DOB ____________________ Today's Date ______________**

| LOCAL PHARMACY: |
|---|
| |
| Phone #: |
| **MAIL ORDER PHARMACY:** |
| |
| Address: |
| City/ ST/Zip: |
| Phone #: |
| Member ID#: |

| MEDICATIONS (including OTC & herbs): | |
|---|---|
| Name: | Mg. / Dosage |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**If more medications, please write on back of this form.**

**ALLERGIES: Are you allergic to any of the following?** ***(Circle all that apply)*** **None Aspirin Penicillin Codeine Metal Latex Local Anesthetics Other: __________________________________**
**If yes, explain the associated allergic reaction: ______________________________________________________________**

**PAST MEDICAL HISTORY**
**Have you been diagnosed with or had the following?** ***(please circle): If yes, please explain below & include age of onset.***

| | | | |
|---|---|---|---|
| AIDS / HIV Positive Yes No | Congenital Heart Disorder Y No | Herpes / Cold Sores Yes No | Scarlet Fever Yes No |
| Alzheimer's Disease Yes No | Depression Yes No | High Cholesterol Yes No | Shingles Yes No |
| Anaphylaxis Yes No | Diabetes Yes No | Hypertension Yes No | Seasonal Allergies Yes No |
| Anemia Yes No | Drug Addiction Yes No | Hypoglycemia Yes No | Sickle Cell Disease Yes No |
| Angina Yes No | Emphysema Yes No | Irregular Heartbeat Yes No | Sleep Apnea Yes No |
| Anxiety Yes No | Epilepsy or Seizures Yes No | Jaundice Yes No | Spina Bifida Yes No |
| Arthritis Yes No | Genital Herpes Yes No | Kidney Stones Yes No | Stroke Yes No |
| Artificial Heart Valve Yes No | Glaucoma Yes No | Leukemia Yes No | Thyroid Disease Yes No |
| Artificial Joint Yes No | Heart Attack Yes No | Liver Disease Yes No | TMJ Yes No |
| Asthma Yes No | Heart Failure Yes No | Migraines Yes No | Tuberculosis Yes No |
| Bi Polar Yes No | Heart Murmur Yes No | Mitral Valve Prolapse Yes No | Ulcers Yes No |
| Blood Transfusion Yes No | Heart Pace Maker Yes No | Osteoporosis Yes No | Venereal Disease Yes No |
| Cancer Yes No | Hemophilia Yes No | Radiation Treatments Yes No | |
| Chemotherapy Yes No | Hepatitis A Yes No | Rheumatic Fever Yes No | |
| Chicken Pox Yes No | Hepatitis B or C Yes No | Rheumatism Yes No | |
| | | | |

**Have you ever had any other serious illness not listed above? Yes No** If yes, please explain & include dates:_________
______________________________________________________________________________________________
______________________________________________________________________________________________

**Have you ever been hospitalized or had a major operation? YES NO If yes, please explain with type of surgery and dates:**_________________________________________________________________________________

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**Adult Immunizations Review – Please list the Date of your Last Immunizations (write N/A if not applicable):**
**Flu: ____________ Pneumonia: ___________ Zostavax (Shingles): ___________ Tetanus/Diptheria: ____________**

## SOCIAL HISTORY:

**Family / Household member (Everyone who lives in your household):**

| Name | Birth Year | Relationship | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Are you on a special diet? YES NO If yes, please explain:**____________________________________________
**Did you or do you smoke cigarettes or use other tobacco products?** ***(please circle)*** **YES NO Type:**_______________
**Age started ___________ Age quit ______________ How many packs per day? ____________**
**Do you use any marijuana, cocaine, or non-prescribed narcotics?** ***(please circle)*** **YES NO**
**If so, please describe: ___________________________________________________________________________**
**How many cups of caffeinated coffee, tea, or carbonated beverage do you drink daily? __________________________**
**How many beers, mixed drinks, or glasses of wine do you have weekly? ______________________________________**

**Occupation:** ______________________________________________ **How long?** _________________________________
**Exposure to loud noises?** **YES / NO** **List:** ____________________________________________
**Highest grade completed: 5 6 7 8 9 10 11 12 Trade School Comm. College 4-Yr College Advanced degree**
**Do you exercise regularly? YES / NO If so, how often?** _____________________________________________
**Description of exercise/activity:** ______________________________________________________________________

## FAMILY HISTORY:

**Has anyone in your immediate family had: (parents, siblings, or grandparents only)**

| History of: | Yes | No | If yes, family relationship(s): | Type: | Age of onset: |
|---|---|---|---|---|---|
| Alcoholism | | | | | |
| Allergies | | | | | |
| Diabetes | | | | | |
| Tuberculosis | | | | | |
| Heart Disease | | | | | |
| Stroke | | | | | |
| High Blood Pressure | | | | | |
| Depression / Anxiety / Bipolar | | | | | |
| Suicide | | | | | |
| Cancer | | | | | |
| High Cholesterol | | | | | |
| Thyroid issues | | | | | |
| Major medical problems | | | | | |

**REVIEW OF SYSTEMS:**

**Do you now have problems with:** (*Mark problems with an "X"*) *If none of the following are complaints, please circle "None."*

| | Present | | Present | | Present |
|---|---|---|---|---|---|
| **1. GENERAL:** | | **5. CARDIOVASCULAR:** | | **8. MUSCULOSKELETAL:** | |
| * **Weight loss, unplanned** | | * **Chest Pain** | | * **Joint Pain** | |
| * **Fatigue** | | * **Irregular Heart Beat** | | * **Joint Swelling** | |
| * **Memory Loss** | | * **Elevated Blood Pressure** | | * **Jaw Pain** | |
| | | * **Heart Disease** | | **9. NEUROLOGICAL:** | |
| **2. HEENT:** | | * **Shortness of Breath** | | * **Blackouts** | |
| * **Headache** | | * **Swelling of Limbs** | | * **Dizziness** | |
| * **Visual Loss** | | **6. GASTROINTESTINAL:** | | * **Seizures** | |
| * **Decreased Hearing** | | * **Bloody Stool** | | * **Stroke** | |
| * **Sinus Pain** | | * **Constipation** | | | |
| * **Hoarseness** | | * **Diarrhea** | | | |
| * **Sore Throat** | | * **Heart Burn** | | **10. PSYCHIATRIC:** | |
| * **Trouble Swallowing** | | * **Jaundice** | | * **Anxiety** | |
| | | * **Kidney Stones** | | * **Depression** | |
| | | * **Nausea** | | * **Sleep Issues** | |
| **3. RESPIRATORY:** | | * **Vomiting** | | **11. ENDOCRINOLOGY:** | |
| * **Cough** | | | | * **Diabetes** | |
| * **Wheezing** | | **7. FEMALE / Genitourinary:** | | * **Excessive Thirst** | |
| | | * **Abnormal PAP smear** | | * **Excessive Urination** | |
| **4. BREAST:** | | * **Urinary Complaints** | | * **Libido Change** | |
| * **Breast Mass** | | * **Blood in Urine** | | **12. HEMATOLOGY:** | |
| * **Breast Pain** | | * **Menstrual Irregularities** | | * **Anemia** | |
| * **Skin Changes** | | | | * **Bleeding Issues** | |

### WOMEN ONLY

Dates of last two Periods ___________ _____________
Current method of contraception ___________________________
Are you pregnant? Yes No Are you breast feeding? Yes No
Are you trying to get pregnant? Yes No

Number of previous:
Pregnancies ________________ Miscarriages ______________
Live Births _________________ Terminations ____________

Age at Menopause ________________
Date of Last: PAP Test: __________________________
Mammogram: __________________________
Dexascan: __________________________
Colonoscopy (50+): ____________________

### MEN ONLY

Do you perform monthly testicular self-exams (TSE)?
☐ Yes ☐ No
Do you have a family history of prostate cancer?
☐ Yes ☐ No
Do you have symptoms of an enlarged prostate? None
☐ Urinary dribbling
☐ Reduced flow
☐ Nighttime urination
Date of Last PSA Test: ______________________
Date of Last Colonoscopy (50+) ______________________