Adult Physicals & New Patients

(Please complete this form if you are here for a physical exam or a new patient to our office).

Patient Name:____D.O.B.________________Date:__________________

Social History-

☐ Married ☐ Single ☐ Divorced; # of children______, Occupation____

Tobacco use-

☐ Never ☐ Social Packs per day-_________for # years___________, Quit- year_________

Alcohol use- # of drinks_________per ☐ Day ☐ Week ☐ Month **Marijuana/ Illicit Drug Use-**_________________________

Do you have any allergies to medication? Please list ☐ **N/A**

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Have you had any previous surgeries? Please list ☐ **N/A**

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Medical Problems/ History:

____

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Family History: Please include the <u>AGE</u> it began—Heart issues, cancer (and type if known), stroke, hypertension, cholesterol, diabetes

☐ Father ____ ☐ Mother ____

☐ Paternal Grandmother________________________________ ☐ Maternal Grandmother ______________________________

☐ Paternal Grandfather ________________________________ ☐ Maternal Grandfather _______________________________

☐ Paternal Aunt _____________________________________ ☐ Maternal Aunt _____________________________________

☐ Paternal Uncle _____________________________________ ☐ Maternal Uncle ____________________________________

☐ Siblings ____

Health Maintenance

Females Only:

Last Mammogram:______________________

Last Pap:______________________________

Last Menstrual Period:___________________

Birth Control: Y / N ______________________

Postmenopausal: Y / N When? _____________

Bone Density: Y / N When? ________________

Hysterectomy: Y / N When? _______________

Patients over 50:

Colonoscopy: Y / N When?____________________________

Shingles Vaccine: Y / N When?_________________________

All Patients:

Last Tetanus Shot:_______________

Last Flu Shot: __________________