INFINITY PRIMARY CARE

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ADULT HISTORY FORM
PLEASE PRINT
(with Blue or Black Ink)

Today's Date:_____
Physician:_____

Name: (last) _____ (first) _____ Date of Birth: _____
Mail Order Pharmacy:_____ Phone:_____ Fax:_____
Local Pharmacy:_____ Phone:_____ Fax:_____
Language Spoken at home:_____

MEDICATIONS:
Please list all medications (include over-the-counter?)
In preparation for your visit bring all medications, inhalers, vitamin or supplements in their original bottles.

NAME STRENGTH FREQUENCY

1._____
2. _____
3._____
4._____
5._____
6. _____
7._____

ALLERGIES:
Are you allergic to any drugs or medications?
☐ NO ☐ YES If yes, what?

Do you have any food allergies?
☐ NO ☐ YES If yes, what?

Any other allergies?
☐ NO ☐ YES If yes, what?

PAIN:
Are you having pain today? NO YES
If yes, on a scale of 1-10
1 =little or no pain and 10 = severe pain
What level are you at? _____

REVIEW OF SYSTEMS: Please check any symptoms you have had RECENTLY

Constitutional
O Chills
O Fatigue
O Fever
O Night sweats
O Weight gain
O Weight loss

HEENT
O Ear drainage
O Ear pain
O Eye discharge
O Eye pain
O Hearing loss
O Nasal drainage
O Sinus pressure
O Sore throat
O Visual changes

Respiratory
O Cough
O Shortness of breath
O Wheezing

Cardiovascular
O Chest pain
O Leg pain when walking
O Edema (swelling)
O Palpitations

Gastrointestinal
O Abdominal pain
O Blood in stool
O Change in stool
O Constipation
O Diarrhea
O Heartburn
O Loss of appetite
O Nausea
O Vomiting

Genitourinary
O Painful urination
O Blood in urine
O Urinary frequency
O Urinary incontinence

Skin
O Hair loss
O Hives
O Itching
O Mole changes
O Rash
O Skin lesion

(Female Only)
O Breast discharge
O Breast lump
O Breast pain

Reproduction
(Female Only)
O Abnormal Pap
O Painful period
O Painful intercourse
O Hot flashes
O Irregular menses
O Vaginal discharge

Last Period_____

(Male Only)
O Erectile dysfunction
O Penile discharge

Neurological
O Dizziness
O Extremity numbness
O Extremity weakness
O Gait disturbance
O Headache
O Memory loss
O Seizures
O Tremors

Psychiatric
O Anxiety
O Depression
O Insomnia

Metabolic/Endocrine
O Cold intolerance
O Heat intolerance
O Excessive thirst
O Excessive hunger

Musculoskeletal
O Back pain
O Joint pain
O Joint swelling
O Muscle weakness
O Neck pain

Hematologic/Lymphatic
O Easy bleeding
O Easy bruising
O Enlarged lymph nodes

Immunologic
O Contact allergy
O Environmental allergies
O Food allergies
O Seasonal allergies

Name: _____ **DOB:**_____

In the last 2 weeks have you felt down, depressed or hopeless? (circle one)

Not at all Several Days More than ½ the days Every Day

Had little or no interest in doing things? (circle one)

Not at all Several Days More than ½ the days Every Day

CHRONIC CONDITIONS: Please mark any illness or disease you have had in the past or currently have:

- O Allergies
- O Anemia
- O Angina
- O Anxiety
- O Arthritis
  Specify_____
- O Asthma
- O Atrial Fibrillation
- O Benign prostatic hypertrophy
- O Blood clots
- O Cancer
  Type_____
- O Cardiac arrhythmia
- O Chronic Insomnia
- O Congestive Heart Failure
- O COPD/Emphysema
- O Coronary artery disease
- O Depression
- O Diabetes
- O High cholesterol
- O Gall bladder disease
- O GERD
- O Glaucoma
- O Gout
- O Head Injury
- O Headache, migraine
- O Heart disease
- O Heart valve disorder
- O Hepatitis/liver disease
- O Hiatal Hernia
- O High Blood Pressure
- O Irritable bowel syndrome
- O Macular Degeneration
- O Heart Attack
- O Osteoporosis
- O Kidney disease
- O Seizure disorder
- O Stomach Ulcers
- O Stroke
- O Thyroid disease

Other-Specify_____

- O Eye Problems
- O Neck/Back Problems
- O Bladder Problems
- O Psychiatric Illness

SURGICAL/HOSPITALIZATION HISTORY: (if marking an item below please include the year it occurred)

- O Angioplasty
- O Appendectomy
- O Arthroscopy
- O Back Surgery
- O Bilateral Tubal Ligation
- O Bladder Suspension
- O Breast Surgery

Type_____

- O Cardiac surgery

Type_____

- O Carpal Tunnel Release
- O Cataract Extraction
- O C-section delivery
- O Cervix Surgery/Procedure
- O Gall Bladder Removal
- O Colectomy
- O Colostomy
- O D and C
- O Gastric Bypass
- O Hernia Repair
- O Hip Replacement
- O Hysterectomy
- O Knee Replacement
- O LASIK
- O Liver Biopsy
- O Myomectomy
- O ORIF (Fracture surgery)
- O Prostate Biopsy
- O Thyroidectomy
- O Tonsillectomy
- O Vasectomy
- O Other_____

What diagnostic, screening studies or immunizations have you had done previously? Please list most recent date.

Complete Physical	_____	Last PAP	_____	Tetanus/Td/Tdap Vaccine	_____
Cardiac Stress Test	_____	Last Mammogram	_____	Pneumonia Vaccine	_____
Colonoscopy	_____	Bone Density (DEXA)	_____	Zostavax/Shingles Vaccine	_____
Cholesterol	_____	Have you had the chicken pox?	_____	Hepatitis A Vaccine	_____
Last Eye Exam	_____	Flu Vaccine	_____	Hepatitis B Vaccine	_____
Last Dental Exam	_____				

Name: _____ DOB:_____

FAMILY HISTORY: Check below to report problems your family members have had. Please state age when they had the problem if you know it.

☐ **Adopted (unknown family history)**

	Mother	Father	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Sister	Brother	Child
ADD/ADHD									
Alcoholism									
Alzheimer's disease									
Aneurysm									
Arthritis (Rheumatoid)									
Asthma									
Blood disorder /Clotting									
Cancer (list type)									
Heart Disease									
Depression									
Diabetes									
Elevated Lipids									
Genetic disease									
High Blood Pressure									
Inflammatory Bowel Syndrome									
Mental Illness									
Migraines									
Obesity									
Osteoporosis									
Seizure disorder									
Stroke									
Thyroid disorder									
Other									
Deceased? Age?									

Name: _____ **DOB:**_____

SOCIAL HISTORY:

Tobacco Usage: ☐ No ☐ Yes ☐ Quit Type?_____If yes or quit, how long? _____ Packs per day? _____

Vaping Usage: ☐ No ☐ Yes ☐ Quit Type?_____If yes or quit, age started? _____ Contain Nicotine? _____

Alcohol Usage: ☐ No ☐ Yes ☐ Quit Type? _____ How Much? _____

Caffeine Usage: ☐ No ☐ Yes ☐ Quit Type? _____ How Much? _____

Drug Usage: ☐ No ☐ Yes ☐ Quit Type? _____ How Much? _____

Occupation:_____ Employed?____ Employer_____

Military Experience: ☐ No ☐ Yes Current status: active reserves discharged retired military

Marital Status: ☐ Married ☐ Single ☐Life Partner ☐Divorced ☐Widowed If married, spouses name: _____

Do you have any children? ☐ No ☐ Yes

# of sons _____ # of daughters _____

# of stepsons _____ # of stepdaughters _____

# of adopted sons _____ #of adopted daughters _____

What is your activity level? Moderate Sedentary Vigorous

Exercise Type: _____Frequency? 2-3 times/week 3-4 times/week daily never occasional

Do you have a religious affiliation? ☐ No ☐ Yes Affiliation:_____

Smoke Detectors in home? ☐ No ☐ Yes Do you wear seat belts? ☐ No ☐ Yes

Carbon Monoxide Detectors in home? ☐ No ☐ Yes Firearms at home? ☐ No ☐ Yes

Radon in home? ☐ No ☐ Yes ☐ Treated ☐ Untreated

Are you sexually active? ☐ No ☐ Yes ☐ Not currently

Please list all specialty Physicians that you have seen in the last year:

Provider Name: _____ Provider Name: _____

Specialty: _____ Specialty: _____

Phone Number: _____ Phone Number: _____

Reason/Diagnosis: _____ Reason/Diagnosis: _____

Provider Name: _____ Provider Name: _____

Specialty: _____ Specialty: _____

Phone Number: _____ Phone Number: _____

Reason/Diagnosis: _____ Reason/Diagnosis: _____

The above information is correct to the best of my knowledge.

_____ _____

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one Date

Physician: _____ **Visit Date: _____**

COMMUNITY LINKAGES SURVEY

We are dedicated to you, our patient and your family. If you are comfortable, please take a moment to answer the following questions so that we can help connect you with local community resources. Our staff is ready to answer any additional questions that you may have.

Please check ☑ Yes or No to the following questions:

1. In the past month, did **poor physical or mental health** keep you from doing your usual activities, like work, school or a hobby? ☐ Yes or ☐ No
2. In the past year, was there a time when you needed to see a doctor but could not because it **cost** too much? ☐ Yes or ☐ No
3. Do you ever eat less than you feel you should because there is not enough **food**? ☐ Yes or ☐ No
4. Do you need a job or other **steady source of income**? ☐ Yes or ☐ No
5. Are you worried that in the next few months, you may not have adequate **housing** that you own, rent or share? ☐ Yes or ☐ No
6. In the past year, have you had a hard time paying your utility company **bills**? ☐ Yes or ☐ No
7. Does getting **child care** make it hard for you to work, go to school or study? ☐ Yes or ☐ No
8. Do you think completing more **education or training**, like earning a high school diploma, going to college, or learning a trade, would be helpful for you? ☐ Yes or ☐ No
9. Do you need a dependable **way to get to work or school** and your appointments? ☐ Yes or ☐ No
10. Do you need **household supplies**? For example, clothing, shoes, blankets, mattresses, diapers, toothpaste, and shampoo. ☐ Yes or ☐ No
11. If you take **medication**, are you not taking it because it is too expensive? ☐ Yes or ☐ No
12. Do you need help **finding or paying for care for loved ones**? For example, child care or day care for an older adult. ☐ Yes or ☐ No
13. Do you **feel unsafe** in your home or living situation? ☐ Yes or ☐ No
    - If you answered ☑ Yes, would you like to receive assistance with any of these needs? ☐ Yes or ☐ No
    - Are any of your needs **<u>urgent</u>**, please write the Number of the Need (1-11)? **_____**

My name: _____ **Date of Birth**: _____

Survey completed by (if other than the patient): _____

My best telephone number: _____

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