FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Adult Health History Questionnaire

Name _____ **Date of Birth** _____

Address _____

Local phone number ( ) _____ **Alternative phone number** ( ) _____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe) _____

Special Communication Needs	
Language preference:	
If 'yes' to any of the questions below, how can we assist?	
Visual impairment	☐ Yes ☐ No
Hearing impairment	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No
Cognitive impairment	☐ Yes ☐ No
Sensory impairment	☐ Yes ☐ No

Personal Health History

Check if you have had any of the following

☐ Hypertension	☐ Bowel/digestive problem
☐ High cholesterol	☐ Atrial Fibrillation
☐ Diabetes	☐ Seizures
☐ Heart attack	☐ Headaches
☐ Angina	☐ Stroke
☐ Irregular heart rhythm	☐ Prostate problem
☐ Congestive heart failure	☐ Breast problem
☐ Emphysema	☐ Urinary tract infections
☐ Chronic Bronchitis	☐ Arthritis
☐ Pneumonia	☐ Thyroid problem
☐ Gastroesophageal reflux disease	☐ Bleeding disorder
(GERD)	☐ Addiction Issues
☐ Asthma	☐ Depression
☐ Osteoporosis	☐ Anxiety
☐ Osteopenia	☐ Mental Illness
☐ Cancer, Type:	Other: _____
☐ Stomach ulcer	
☐ Kidney Disease	
☐ Liver Disease	

Previous Surgical Procedures

Check if you have had any of the following

Procedure	Year
☐ Heart surgery	
☐ Pacemaker	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy ☐ Abdominal ☐ Vaginal	
☐ Ovary Removal ☐ Right ☐ Left ☐ Bilateral	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Tonsillectomy	
☐ Joint replacement ☐ Knee ☐ Right ☐ Left	
☐ Hip ☐ Right ☐ Left	
☐ Spine Surgery ☐ Neck ☐ Back	
☐ Mastectomy ☐ Right ☐ Left ☐ Bilateral	
☐ Breast lumpectomy	
☐ Hernia	
☐ Prostate cancer surgery	
☐ Other: _____	

Social History

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Occupation: _____ **Concerns**: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Retired

Tobacco use: ☐ Never ☐ Quit (when) _____ ☐ Current smoker: Packs/day, how many years _____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often _____

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often _____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current

Describe: _____

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain/discomfort	☐ Rectal bleeding	☐ Eye pain	☐ Pain in testicles
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Loss of libido
☐ Wheezing	☐ Hemorrhoids	☐ Double vision	☐ Impotence
☐ Cough	☐ Diarrhea	☐ Memory lapses or loss (Forgetfulness)	☐ Breast pain
☐ Coughing up blood	☐ Constipation	☐ Ringing in ears	☐ Breast discharge
☐ Sore throat	☐ Weight loss (lbs.)	☐ Pain in ears	☐ Other (please describe below)
☐ Nasal congestion	☐ Weight gain (lbs.)	☐ Nose bleeds	
☐ Irregular heartbeat	☐ Loss of appetite	☐ Hoarseness	
☐ Fast heartbeat	☐ Difficulty swallowing	☐ Easy bleeding	
☐ High blood pressure	☐ Painful urination	☐ Easy bruising	
☐ Low blood pressure	☐ Blood in urine	☐ Rash	
☐ Lightheadedness	☐ Urine frequency	☐ Changes in a mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Decrease in urine flow	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Urine leakage	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐Pain/cramps
☐ Heartburn	☐ Headaches, frequent	☐ Insomnia	Days of flow: Length of cycle:
☐ Indigestion	☐ Loss of strength	☐ Depression	1st day of last period:
☐ Ankle swelling	☐ Balance problems	☐ Nervousness	☐ Pain or bleeding after sex
☐ Nausea	**Pain, weakness, or numbness in:**		Number of pregnancies:
☐ Vomiting	☐ Arms ☐ Hips	☐ Back	Number of Miscarriages:
☐ Vomiting blood	☐ Legs ☐ Neck	☐ Shoulders	Birth control method :
☐ Change in bowel habits	☐ Hands ☐ Feet	☐ Abdomen	Menopause ☐ Y ☐ N Age:

Family History

Father ☐ Living ☐ Deceased at age ____
Mother ☐ Living ☐ Deceased at age ____
Brother(s) ☐ Living ☐ Deceased at age ____
Brother(s) ☐ Living ☐ Deceased at age ____
Brother(s) ☐ Living ☐ Deceased at age ____
Sister(s) ☐ Living ☐ Deceased at age ____
Sister(s) ☐ Living ☐ Deceased at age ____
Sister(s) ☐ Living ☐ Deceased at age ____
☐ Adopted/Family Health History Unobtainable

Please check all that apply

	Father	Mother	Brother	Sister
Denies Significant Symptoms				
Alcoholism				
Allergies				
Alzheimer's				
Anxiety Disorder				
Arthritis				
Asthma				
Bleeding Problems				
Cancer/Type				
Drug Dependence				
Depression				
Diabetes				
GI Disorders				
Glaucoma				
Heart attack				
Heart Disease				
HIV				
Hyperlipidemia (Elevated Cholesterol)				
Hypertension				
Kidney Disease				
Liver Disease				
Lung Disease				
Mental/Psychiatric Disorder				
Migraines				
Neurological Disorder				
Seizure Disorder				
Stroke				
Thyroid Disorder				
Other				

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance						
Please check whether you have had the following preventative services and enter the month and year of the service						
Immunizations	Last Occurrence Month	Year		Tests	Last Occurrence Month	Year
Tetanus vaccine / Tdap				☐ Mammogram Screening/Bilateral ☐ Left Breast ☐ Right Breast		
Pneumonia vaccine ☐ Pneumovax 23 ☐ Prevnar 13				Colorectal Cancer Screening ☐ Colonoscopy ☐ Other:_____		
Influenza vaccine				Pap smear/pelvic		
Shingles vaccine ☐ Zostavax ☐ Shingrix				Chest X-Ray		
Hepatitis A				Prostate-Specific Antigen (PSA)		
Hepatitis B						
Gardasil (HPV)				Bone Density		

Allergies	
Please list any allergies to medications or foods	
Name	Symptom/Reaction

Recently Hospitalized		
Date	Hospital	Reason for admission

Medications		
Please list any medications that you take including over the counter medications, herbs, and supplements.		
Name	**Dose**	**Frequency**

Local Pharmacy: _____ **Phone**: ( ) _____ - _____

Location: _____ **City** _____ **State:** _____

Secondary Pharmacy: _____ **Phone**: ( ) _____ - _____

Location: _____ **City** _____ **State:** _____

Specialty Providers	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice	
Cardiologist Name: _____ Phone: _____ Last Seen: _____	**Nephrologist** Name: _____ Phone: _____ Last Seen: _____
Ophthalmologist Name: _____ Phone: _____ Last Seen: _____	**Psychiatrist/Psychologist** Name: _____ Phone: _____ Last Seen: _____
Oncologist Name: _____ Phone: _____ Last Seen: _____	**Allergist** Name: _____ Phone: _____ Last Seen: _____
Urologist Name: _____ Phone: _____ Last Seen: _____	**Gynecologist** Name: _____ Phone: _____ Last Seen: _____
Gastroenterologist Name: _____ Phone: _____ Last Seen: _____	**Pulmonologist** Name: _____ Phone: _____ Last Seen: _____
Endocrinologist Name: _____ Phone: _____ Last Seen: _____	**Podiatrist** Name: _____ Phone: _____ Last Seen: _____
Other Name: _____ Phone: _____ Last Seen: _____	**Other** Name: _____ Phone: _____ Last Seen: _____

Patient/Guardian Signature: _____ Date: _____