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 ☐ Current Concerns _____

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

☐ Acute myocardial infarction	☐ Hepatic disorders
☐ Atrial Fibrillation	☐ Renal disease
☐ Angina pectoris	☐ Prostate disorders
☐ Congestive heart failure	☐ Urinary Tract Infection
☐ Hyperlipidemia	☐ Arthritis
☐ Hypertension	☐ Neuropathy
☐ Cardiac rhythm disorder	☐ Epilepsy and recurrent seizures
☐ Asthma	☐ Headache syndromes
☐ Chronic bronchitis	☐ Stroke syndrome
☐ Emphysema	☐ Aneursym
☐ Pneumonia	☐ Coagulation disorders
☐ Gastroesophageal reflux disease (GERD)	☐ Cancer-please specify location:
☐ IBS (Irritable Bowel Syndrome)	☐ Breast disorder
☐ Disease of digestive system	☐ Anxiety disorder
☐ Peptic ulcer	☐ Depressive episode
☐ Diabetes mellitus	☐ Unspecified mental disorder nonpsychotic
☐ Osteopenia	☐ Substance abuse
☐ Osteoporosis	☐ Other diagnoses and conditions
☐ Thyroid disorders	

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	
☐ Total Colectomy	
☐ 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: _____ ☐ Full Time/Part-time ☐ Retired Concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting

Exercise: ☐ Yes ☐ No If yes, how many minutes per day? _____ How many days of exercise in the last 7 days? _____

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

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

Caffeine use: ☐ Yes ☐ No If yes, how many cups per day? _____

Illicit Drug use (including cocaine, steroids, etc): ☐ Never ☐ Past ☐ Current ☐ Marijuana by Prescription

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:
☐ 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	☐ Lower 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 ☐ Deceased at age ____ Mother ☐ Deceased at age ____
Brother(s) ☐ Deceased at age ____ Sister(s) ☐ Deceased at age ____
Brother(s) ☐ Deceased at age ____ Sister(s) ☐ Deceased at age ____
Brother(s) ☐ Deceased at age ____ Sister(s) ☐ Deceased at age ____

☐ Adopted/Family Health History Unobtainable

Please check all that apply

	Father	Mother	Brother	Sister
Denies Significant Symptoms				
Alcoholism				
Allergies				
Alzheimer's				
Aneurysm				
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				
Migranes				
Nuerological Disorder				
Neuropathy				
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			Breast Cancer Screening ☐ Mammogram Bilateral ☐ Left Breast ☐ Right Breast		
Pneumonia vaccine ☐ Pneumovax 23 ☐ Prevnar 13 ☐ Vaxneuvance ☐ Prevnar 20			Cervical Cancer Screening ☐ Pelvic exam ☐ Pap smear ☐ Positive ☐ Negative		
Influenza vaccine			Human Papilloma Virus Screening (HPV) ☐ Positive ☐ Negative		
Shingles vaccine ☐ Zostavax ☐ Shingrix			Colorectal Cancer Screening ☐ Colonscopy (Next due in ____ years) ☐ FOBT (Stool Lab Test) ☐ Positive ☐ Negative ☐ Flexible Sigmoidoscopy ☐ Cologuard		
Hepatitis A			Chest X-Ray		
Hepatitis B			Prostate-Specific Antigen (PSA)		
Gardasil (HPV)			Bone Density		
			Low Dose CT Lung		

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:** _____

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

Patient/Guardian Signature: _____ Date: _____

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