FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Adult Health History Questionnaire

Name : ______________________ **Date of Birth :** ______________

Local Pharmacy: ______________________ **Phone:** ( ) ______ - ______

Location: ______________________ **City** ______________ **State:** ______

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

Location: ______________________ **City** ______________ **State:** ______

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

Previous Surgical Procedures

Check if you have had any of the following

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

Social History

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

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

Occupation: ____________________ **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:

Recent Hospitalizations

Date	Hospital	Reason for admission

Allergies

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Frequency

Family History				
Father ☐ Deceased at age ____				
Mother ☐ Deceased at age ____				
Brother(s) ☐ Deceased at age ____				
Brother(s) ☐ Deceased at age ____				
Brother(s) ☐ Deceased at age ____				
Sister(s) ☐ Deceased at age ____				
Sister(s) ☐ Deceased at age ____				
Sister(s) ☐ Deceased at age ____				
☐ Adopted/Family Health History Unobtainable				
Please check all that apply				
Condition	**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				
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?				

Other Care Providers 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: ________	**Urologist** Name: ____________ Phone: ________ Last Seen: ________
Oncologist Name: ____________ Phone: ________ Last Seen: ________	**Other** Name: ____________ Phone: ________ Last Seen: ________

Patient/Guardian Signature: ______________________________ Date: ______________