

Little Rivers Health Care, Inc.

New Patient Adult Personal History

Name: _____ Birth Date: _____ Today's Date: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Occupation: _____ How long: _____ Religious preference: _____

Education/highest degree completed: _____

Please list all members of your household: _____

Please list all states and countries where you have lived: _____

Previous Health Care Provider: _____ Last Physical Exam: _____

List any Specialty Physicians: _____

List any Alternative or Complementary Care Providers: _____

List any **Allergies** (medications &/or environmental): _____

List any **Medications** you use (prescription &/or over-the-counter): _____

Have you had any of these?-If yes, please indicate date of last one:

Pap Smear _____ Cholesterol test _____ Hemoccult Stool _____

Dental Exam _____ Eye Exam _____ Colonoscopy _____

Tetanus shot _____ Flu shot _____ Pneumonia shot _____

Hep B vaccine _____ Hep A vaccine _____ Shingles vaccine _____

Mammogram _____ Prostate exam _____ Bone Density/DEXA _____

Check the box if any of these currently apply:

- | | |
|--|---|
| <input type="checkbox"/> Exercise on regular basis | <input type="checkbox"/> Have an Organ Donor Card |
| <input type="checkbox"/> Wear a seat belt | <input type="checkbox"/> Have a Living Will |
| <input type="checkbox"/> Use protective gear (i.e. bike helmet) | <input type="checkbox"/> Have a Durable Power of Attorney |
| <input type="checkbox"/> Use sunscreen | |
| <input type="checkbox"/> Have guns in the home | |
| <input type="checkbox"/> Consume/ Eat a special diet _____ | |
| <input type="checkbox"/> Avoid certain foods. If so, please list: _____ | |
| <input type="checkbox"/> Do/Did you ever use tobacco products? If so packs per day _____ Number of years _____ | |
| <input type="checkbox"/> Drink alcohol. If so, how many drinks in a week? _____ per week | |
| <input type="checkbox"/> Use 'street drugs' such as marijuana, cocaine, heroin, narcotic pain pills? _____ | |
| <input type="checkbox"/> Use prescription narcotic pain pills? _____ | |

***Continued on reverse side**

Past Medical History

Are your parents still living? Mother: yes no Father: yes no

If not, age & cause of death: Mother: _____ Father: _____

Past Medical History- Current, Past and/or Family History of:

If you were adopted, please complete the family history portion as completely as you can.

(check ONLY if applies)

	You	Family Member		You	Family Member
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Anemia	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Stroke	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Asthma	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/> Who? _____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	HIV Positive	<input type="checkbox"/>	
Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Polio or Meningitis	<input type="checkbox"/>	
Colitis	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Rheumatic Fever	<input type="checkbox"/>	
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Sexually Transmitted Disease	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Migraine Headaches	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Stomach Ulcers	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Gout	<input type="checkbox"/>	
Gallbladder Surgery	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Hemorrhoids	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Hepatitis/Liver disease	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Chicken Pox	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Eating Disorder	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Who? _____	Frequent infections/boils	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/> Who? _____			
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/> Who? _____			
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/> Who? _____			
Obesity	<input type="checkbox"/>	<input type="checkbox"/> Who? _____			

Other serious disease or illness or injury: _____

Do you have concerns regarding you health or safety due to the work you do? _____

Do you have concerns regarding you health or safety because of where you live (house, region)? _____

Do you have any known limitations? _____

Prior Worker's Compensation or Disability injuries (Brief details and dates) _____

Surgeries & Hospitalizations

Tonsillectomy Date _____ Hospital _____ Hysterectomy Date _____ Hospital _____
Appendectomy Date _____ Hospital _____ Vasectomy Date _____ Hospital _____
Gallbladder Date _____ Hospital _____ Tubal Ligation Date _____ Hospital _____

Other operations:

Type _____ Date _____ Hospital _____
Type _____ Date _____ Hospital _____
Type _____ Date _____ Hospital _____

Any complications from surgery? yes no If yes, explain _____

Any problems from anesthesia? yes no If yes, explain _____

Ever had a blood transfusion? yes no If yes, date and reason _____

Please list reasons for all other hospitalizations &/or Emergency Department visits:

_____ Date _____ Hospital _____
_____ Date _____ Hospital _____
_____ Date _____ Hospital _____
_____ Date _____ Hospital _____

WOMEN ONLY – Menstrual History

Age at first period: _____ Age at menopause, if appropriate: _____

Are your periods regular? yes no If no, please explain _____

How many days do you bleed? _____ How often do they come? _____

Do you have any bleeding between periods? yes no If yes, please explain _____

Do you have to miss work or school due to painful periods? yes no

If you use birth control what method? _____

How many pregnancies have you had? _____ How many live children born? _____

Any miscarriages or abortions? _____ How many cesarean-sections? _____

Any complications w/ pregnancy? _____

Do you perform periodic self-breast exams? yes no Have you noticed any lumps? yes no