ADULT HISTORY & ANNUAL PHYSICAL FORM **www.familywellnesscntr.com**

NAME _____ **DOB** _____ **Today's Date** _____

MEDICATIONS (including OTC & herbs):		
Name:	Mg. / Dosage	Reason why you are taking?

If you have more medications or medical history than can fit on form, please write on back of this form.

LOCAL PHARMACY:
Phone #:
MAIL ORDER PHARMACY:
Address:
City/ ST/Zip:
Phone #: Member ID#:

PAST MEDICAL HISTORY	**Date**
1.	
2.	
3.	
4.	
5.	

Have you ever been hospitalized or had an operation? YES NO If yes, please explain with type of surgery and dates: _____

Adult Immunizations Review – Please list the Date of your Last Immunizations (write N/A if not applicable):
Flu: _____ Pneumonia: _____ Shingles: _____ TDaP (Tetanus, Diptheria & Pertussis):_))_____

REVIEW OF SYSTEMS:
Mark (X) if you have any of these conditions currently or in the past. If no medical complaints please circle: NONE

	Present	Past		Present	Past		Present	Past
1. GENERAL:			**6. CARDIOVASCULAR:**			**9. MUSCULOSKELETAL:**		
Weight loss			**Chest Pain**			**Joint Pain**		
Fatigue			**Irregular Heart Beat**			**Joint Swelling**		
Memory Loss			**Elevated Blood Pressure**			**Jaw Pain**		
			Heart Disease			**10. NEUROLOGICAL:**		
2. HEENT:			**Shortness of Breath**			**Blackouts**		
Headache			**Swelling of Limbs**			**Dizziness**		
Visual Loss						**Seizures**		
Decreased Hearing			**7. ENDOCRINOLOGY:**			**Stroke**		
Sinus Pain			**Diabetes**			**11. PSYCHIATRIC:**		
Hoarseness			**Excessive Thirst**			**Anxiety**		
Sore Throat			**Excessive Urination**			**Depression**		
Trouble Swallowing			**Libido Change**			**Sleep Issues**		
3. RESPIRATORY:			**8. GASTROINTESTINAL:**			**MALE/Genitourinary**		
Cough			**Bloody Stool**			**Urinary dribbling**		
Wheezing			**Constipation**			**Reduced flow**		
4. BREAST:			**Diarrhea**			**Nighttime urination**		
Breast Mass			**Heart Burn**			**FEMALE / Genitourinary:**		
Breast Pain			**Jaundice**			**Abnormal PAP smear**		
Skin Changes			**Kidney Stones**			**Urinary Complaints**		
5. HEMATOLOGY:			**Nausea**			**Blood in Urine**		
Anemia			**Vomiting**			**Menstrual Irregularities**		
Bleeding Issues								

ALLERGIES: **Are you allergic to any of the following?** ***(Circle all that apply)*** **None Aspirin Penicillin Codeine Metal Latex Local Anesthetics Other: _____**
If yes, explain the reaction: _____ Anaphylaxis: YES / NO

SOCIAL HISTORY:

Family / Household member (Everyone who lives in your household):

Name	Birth Year	Relationship	

Did you EVER or do you smoke cigarettes or use other tobacco products? ***(please circle)*** **YES NO**
Type:_____
Age started _____ Age quit _____ How many packs per day? _____
Do you use any marijuana, cocaine, or non-prescribed narcotics? ***(please circle)*** **YES NO**
If so, please describe: _____
How many cups of caffeinated coffee, tea, or carbonated beverage do you drink daily? _____
How many beers, mixed drinks, or glasses of wine do you have weekly? _____

FAMILY HISTORY:

Please check if Mother, Father, Brother/Sister or Grandparents have had any of the following: For Grandparents, please indicate M for Mother's side of family or P for Father's side of family.

	Mother	Father	Brother/Sister	Grandmother	Grandfather	Age at onset
Alcoholism						
Allergies						
Diabetes						
Tuberculosis						
Heart Disease						
Stroke						
High Blood Pressure						
Depression / Anxiety / Bipolar						
Suicide						
Cancer						
High Cholesterol						
Thyroid issues						
Major medical problems						

WOMEN ONLY

Dates of last two Periods _____ _____

Current method of contraception _____

Number of previous:
Pregnancies _____ Miscarriages _____
Live Births _____ Terminations _____

AGE at Menopause _____

Date of Last: PAP Test: _____
Mammogram: _____
Dexascan: _____
Colonoscopy (50+): _____

MEN ONLY

Do you perform monthly testicular self-exams (TSE)?

☐ Yes ☐ No

Date of Last PSA Test: _____

Date of Last Colonoscopy (50+) _____