Name:______________________________________ Date:______________________

ADULT MEDICAL HISTORY FORM

Your answers on this form will help your provider better understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific dates. Thank you!

Age:____________ How would you rate your general health? ___Excellent ___Good ___Fair ___Poor

Main reason for today's visit:____

Other concerns I would like to discuss if there's time:____

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
____Fevers/sweats/weakness
____Unexplained weight loss/gain

Eyes
____Change in vision

Ear/Nose/Throat/Mouth
____Difficulty hearing/ringing in ears
____Hay fever/allergies

Cardiovascular
____Chest pain/discomfort
____Palpitations

Breast
____Breast lump/nipple discharge

Respiratory
____Cough/wheeze

Gastrointestinal
____Blood in bowel movement
____Nausea/vomiting/diarrhea

Genitourinary
____Nighttime urination
____Leaking urine
____Unusual vaginal bleeding
____Discharge: penis or vagina

Musculoskeletal
____Muscle/joint pain

Skin
____Rash/new or change in mole

Neurological
____Headaches
____Memory loss

Psychiatric
____Anxiety
____Sleep problem
____Depression

Blood/Lymphatic
____Unexplained lumps
____Easy bruising/bleeding

Other
____Concern with sexual function

In the past month, have you had little interest or pleasure in doing things or felt down, depressed or hopeless?
___Yes ___No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g. mg/pill)	How many times per day
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

Date of your most recent IMMUNIZATIONS:

Hepatitis A__________ Hepatitis B__________ Influenza (flu shot)_______ TdaP (tetanus,pertussis)____________

Pneumovax 23 (pneumonia)__________ Prevnar 13 (pneumonia)______________ Tetanus (Td)__________

Varicella (Chicken pox) shot or illness__________ MMR (Measles, Mumps, Rubella)__________

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)_________________________________ Date________________ Abnormal? ___Yes ___No

Sigmoidoscopy__________ or Colonoscopy____________ Date________________ Abnormal? ___Yes ___No

Women: Mammogram_______ Date_________ Abnormal? ___Yes ___No

Pap Smear______ Date__________ Abnormal? ___Yes ___No

Men: PSA (prostate)_________Date__________ Abnormal? ___Yes ___No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems with dates.

________Heart disease
specific type____________
________Heart attack
________High blood pressure
________Diabetes
________Other: (specify)_________
________High cholesterol
________Thyroid problem

SURGICAL HISTORY: Please list all prior operations with dates:____
____
____

FAMILY HISTORY: Please indicate current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism______________________________________
Cancer, specify type______________________________
Heart Attack_____________________________________
Depression/Suicide_______________________________
Diabetes____
High Cholesterol_________________________________
High Blood Pressure______________________________
Stroke____
Other____
Other____

SOCIAL HISTORY:

Tobacco Use
Cigarettes ___Never ___Quit, date___________
___Current smoker, packs/day_____, #of yrs____
Other tobacco: ___Pipe ___Cigar ___Snuff ___Chew
Are you interested in quitting? ___Yes ___No

Alcohol Use
Do you drink alcohol? ___Yes ___No, # drinks/week____
Is your alcohol use a concern for you or others? ___Yes ___No

Drug Use
Do you use any recreational drugs? ___Yes ___No
Have you ever used needles to inject drugs? ___Yes ___No

Sexual Activity
Sexually active: ___Yes ___No ___Not currently
Current sex partner(s) is/are: ___Male ___Female
Birth control method:______________, or ____None needed
Have you ever had any sexually transmitted disease (STDs)? ___Yes ___No
Are you interested in being screened for sexually transmitted disease? ___Yes ___No

Other Concerns
Caffeine Intake: ___None ___Coffee/tea/soda ____cups per day
Weight: Are you satisfied with your weight? ___Yes ___No
Diet: How do you rate your diet? ___Good ___ Fair ___Poor
Do you eat or drink 4 servings of dairy or soy daily or take calcium supplements? ___Yes ___No
Exercise: Do you exercise regularly? ___Yes ___No
What kind of exercise?_____________
How long (minutes)________ How often?_________
If you do not exercise, why?_____________________
Safety: Do you use a bike helmet? ___Yes ___No
Do you use seatbelts constantly? ___Yes ___No
Is violence at home a concern for you ___Yes ___No
Have you ever been abused? ___Yes ___No
Do you have a gun in your home? ___Yes ___No

SOCIOECONOMICS:
Occupation:____ Employer:____
Years of education/highest degree:____
Marital Status: ___Single ___Partner/Married ___Divorced ___Widowed Other:_______________________________
Spouse/partner's name:___________________________ Number of children/ages:______________________________
Who lives at home with you?____

WOMEN'S HEALTH HISTORY:

# of pregnancies_____ # of deliveries______ # of abortions______ # of miscarriages
1st day of most recent period:_________________

Patient First & Last Name ______________________

Patient Date of Birth ______________________

Patient Primary Care Physician ______________________

Assessment for Social Needs

Primary Care Specialists, P.C.
33611 Warren Road
Westland, MI 48185

Today's Date ______________________

As your Patient-Centered Medical Home, we are happy to partner with you, to help you and your family in times of need. From the answers below, we maintain a list of trusted community resources that care about you as much as we do.

Please Answer the following questions:	Yes	No	Decline to Answer
In the past month, did poor health keep you from doing your usual activities, like work, school, or a hobby?	☐	☐	☐
In the past 12 months, was there a time when you needed to see a doctor but could not because it cost too much?	☐	☐	☐
In the past 12 months, did you ever eat less than you needed to because there was not enough food?	☐	☐	☐
Is it hard to find work or another source of income to meet your basic needs?	☐	☐	☐
Are you worried that in the next 2 months, you may not have housing?	☐	☐	☐
In the past 12 months, have you had a hard time paying your utility company bills?	☐	☐	☐
Do you need help finding or paying for care for loved ones? For example, childcare or day care for an older adult.	☐	☐	☐
Do you want help with school or job training, like finishing a GED, going to college, or learning a trade?	☐	☐	☐
In the past 12 months, have you had trouble getting to school, work, or the store because you do not have a way to get there?	☐	☐	☐
Do you ever feel unsafe in your home or neighborhood?	☐	☐	☐
Over the last 2 weeks, have you had a great deal of stress or felt overwhelmed?	☐	☐	☐
Over the last 2 weeks, have you felt a lot of anxiety or scared?	☐	☐	☐
Over the last 2 weeks, have you felt depressed or very sad?	☐	☐	☐
*If you answered yes, would you like to receive assistance with any of these needs?	☐	☐	☐
*Are any of your needs urgent? For example, I need food/shelter for tonight.	☐	☐	☐

FOR OFFICE STAFF ONLY: **PRIMARY INSURANCE, MEMBER ID**______________________

Is patient being provided care management or care coordination services?			

Referrals	Due Date/Follow-Up
1.	
2.	

Patient Health Questionnaire (PHQ-9)

Patient Name:____ Date:_______________

	Not at all	Several days	More than half the days	Nearly every day
1. Over the <u>last 2 weeks</u> how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				
THIS ROW FOR DOCTOR'S USE ONLY SCORE:	0	1	2	3
(add columns)		+	+	+
TOTAL SCORE:	=			
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				