Hillsborough Medical Assoc.

ADULT PATIENT INFORMATION

PATIENT INFORMATION

Name _____ Date of birth: _____

Phone Number _____ Today's Date: _____

Allergies: _____

Is patient adopted ❑ Yes ❑ No

Interpreter needed ❑ Yes ❑ No _____

Medications

Please list all the medications you are taking, including any vitamins, herbal medicines, and "over-the-counter" medications.

Name of medication	Dose	Frequency

Medical History

If your answer is "Yes" to a question, please explain on the line following the question.

None ..... ❑ Yes ❑ No _____

Thyroid Problems..... ❑ Yes ❑ No _____

Seizures..... ❑ Yes ❑ No _____

Stroke ..... ❑ Yes ❑ No _____

Asthma ..... ❑ Yes ❑ No _____

C.O.P.D. ..... ❑ Yes ❑ No _____

Sleep Apnea ..... ❑ Yes ❑ No _____

Coronary Artery Disease ..... ❑ Yes ❑ No _____

Congestive Heart Failure ..... ❑ Yes ❑ No _____

Chest Pain ..... ❑ Yes ❑ No _____

High Blood Pressure ..... ❑ Yes ❑ No _____

Elevated Cholesterol ..... ❑ Yes ❑ No _____

Heart Attack ..... ❑ Yes ❑ No _____

Implantable Devices ..... ❑ Yes ❑ No _____

Cardiac Arrhythmia ..... ❑ Yes ❑ No _____

Rheumatic Fever..... ❑ Yes ❑ No _____

Diabetes ..... ❑ Yes ❑ No _____

Liver Problems ..... ❑ Yes ❑ No _____

Stomach Problems..... ❑ Yes ❑ No _____

Irritable Bowel Syndrome ..... ❑ Yes ❑ No _____

Reflux (G.E.R.D.)..... ❑ Yes ❑ No _____

Kidney Problems ..... ❑ Yes ❑ No _____

Incontinence of Urine ..... ❑ Yes ❑ No _____

Medical History *(continued)*

Genitourinary Problems ..... ❑ Yes ❑ No _____
Osteoporosis ..... ❑ Yes ❑ No _____
Back or Neck Problems ..... ❑ Yes ❑ No _____
Arthritis ..... ❑ Yes ❑ No _____
Skin Problems ..... ❑ Yes ❑ No _____
Anemia ..... ❑ Yes ❑ No _____
Blood Disorder ..... ❑ Yes ❑ No _____
M.R.S.A. / V.R.E. ..... ❑ Yes ❑ No _____
Tuberculosis ..... ❑ Yes ❑ No _____
C-difficile ..... ❑ Yes ❑ No _____
Hepatitis ..... ❑ Yes ❑ No _____
HIV or AIDS ..... ❑ Yes ❑ No _____
STDs ..... ❑ Yes ❑ No _____
Depression ..... ❑ Yes ❑ No _____
Anxiety ..... ❑ Yes ❑ No _____
Eating Disorder ..... ❑ Yes ❑ No _____
Menstrual Problems ..... ❑ Yes ❑ No _____
Abnormal Pap Smear ..... ❑ Yes ❑ No _____
Cancer ..... ❑ Yes ❑ No _____
Other Medical Problems ..... ❑ Yes ❑ No _____
Hospitalizations ..... ❑ Yes ❑ No _____
Are immunizations on schedule ..... ❑ Yes ❑ No _____
Previous reaction to immunizations..... ❑ Yes ❑ No _____

Surgical History

If your answer is "Yes" to a question, please explain on the line following the question.

None ..... ❑ Yes ❑ No _____
Appendectomy ..... ❑ Yes ❑ No _____
Breast Biopsy..... ❑ Yes ❑ No _____
Cholecystectomy ..... ❑ Yes ❑ No _____
Coronary Artery Bypass ..... ❑ Yes ❑ No _____
Hernia ..... ❑ Yes ❑ No _____
Hip Replacement ..... ❑ Yes ❑ No _____
Hysterectomy..... ❑ Yes ❑ No _____
Knee Replacement ..... ❑ Yes ❑ No _____
Other surgical procedures ..... ❑ Yes ❑ No _____

Social History

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other: _____

Occupation: _____

Highest level of education: ❑ College ❑ High school ❑ G.E.D. ❑ Other: _____

Number of living children: _____

Do you have special religious or cultural needs: ❑ Yes ❑ No _____

Family History

Please indicate which of your relatives has had any of the following conditions.

	Parent		Parent		Maternal		Maternal		Paternal		Paternal		Siblings	
	Mother	Age of Onset	Father	Age of Onset	Grand-mother	Age of Onset	Grand-father	Age of Onset	Grand-mother	Age of Onset	Grand-father	Age of Onset	Sister	Brother
Unknown ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Aneurysms ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Bleeding tendencies ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Breast cancer ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Colo-Rectal Cancer ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Ovarian cancer ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Pancreatic cancer ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Other cancers ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Diabetes ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Alcohol dependence ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Drug abuse ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Heart problems ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Hypertension ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Stroke ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Mental illness ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐
Other health problems ☐ Y ☐ N	☐		☐		☐		☐		☐		☐		☐	☐

Is your father deceased ☐ Yes ☐ No _____

Is your mother deceased ☐ Yes ☐ No _____

HEALTH RISK PROFILE

If your answer is "Yes" to a question, please explain on the line following the question.

Latex Allergy Risk

Allergic to latex ☐ Yes ☐ No _____

Reaction to a medical procedure ☐ Yes ☐ No _____

Reaction to a dental procedure ☐ Yes ☐ No _____

Allergic to bananas ☐ Yes ☐ No _____

Allergic to kiwis ☐ Yes ☐ No _____

Allergic to avocados ☐ Yes ☐ No _____

Allergic to chestnuts ☐ Yes ☐ No _____

Smoking Status

Current every day smoker ☐ Yes ☐ No _____

Current some day smoker ☐ Yes ☐ No _____

Former smoker ☐ Yes ☐ No _____

Never smoker ☐ Yes ☐ No _____

Smoker current status unknown ☐ Yes ☐ No _____

Unknown if ever smoke ☐ Yes ☐ No _____

Exposure to secondhand smoke ☐ No ☐ Yes (If "yes," who and where?): _____

Other tobacco use ☐ Yes ☐ No _____

Alcohol Use ☐ Yes ☐ No _____

Recreational Drug Use ☐ Yes ☐ No _____

Caffeine Use ☐ Yes ☐ No _____