Adult Annual Visit

MRN_____________________ **Today's Date _____________**

Name____ **Date of Birth_____________**

List anyone else involved with your care including other medical providers:

SOCIAL HISTORY:

Marital Status: ___________________________________ **Do you have an Advance Directive? YES/NO**

Are you currently employed? YES / NO -- Occupation: ____

Describe your current physical activities: ____

Describe your current diet: ____

Tobacco Use:

Have you smoked tobacco within the last 30 days?.....................................YES/NO **Never: _____**

Former Smoker: _____ **How Many? __________** **Quit When? __________**

Current Smoker: _____ **How Many? __________** **How Long? __________**

Interest in Quitting? YES / NO

Alcohol Use: How many drinks per week? _____

Alcohol: One drink = 12 oz. beer 5 oz. wine 1.5 oz. liquor (one shot)

	None	1 or More
MEN: How many times in the past year have you had 5 or more drinks in a day?		
WOMEN: How many times in the past year have you had 4 or more drinks in a day?		

Recreational Drug Use:

Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

Are you currently using or have you ever used recreational drugs? YES / NO

If yes, what kind? _____________________________ **For how long?______________________**

DEPRESSION SCREENING:

Over the last 2 weeks, how often have you been bothered by any of the following:

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
	0	1	2	3
1. Little interest or pleasure in doing things:				
2. Feeling down, depressed or hopeless:				

ALLERGIES: **(Please list any food or drug allergies)**

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CURRENT MEDICATIONS: **(Please include supplements and non-prescription medications)**

1. ______________________	11. ______________________
2. ______________________	12. ______________________
3. ______________________	13. ______________________
4. ______________________	14. ______________________
5. ______________________	15. ______________________
6. ______________________	16. ______________________
7. ______________________	17. ______________________
8. ______________________	18. ______________________
9. ______________________	19. ______________________
10. ______________________	20. ______________________

FAMILY HISTORY:

Have your parents, brothers, sisters or children ever been treated for (circle yes or no):

Cancer…………………………	**YES / NO**	**Who? ___________**	**High Blood Pressure…………**	**YES / NO**	**Who?_________**
Nervous Disorders……..….	**.YES / NO**	**Who? ___________**	**Heart Disease…………………**	**YES / NO**	**Who?_________**
Diabetes………………………...	**YES / NO**	**Who? ___________**	**Blood Disease ……...…………**	**YES / NO**	**Who?_________**

HISTORY OF MEDICAL CARE:

Last Eye Exam: ___________________________ **Last Colon Cancer Screening:**_______________

For women:

Last Pap Smear:_______________________________ **Last Mammogram:**_____________________________

If you are 50 years old or under: Would you like to become pregnant in the next year?..................YES/NO

Current method of birth control: ___________________________________

PAST MEDICAL HISTORY:

Have YOU ever been treated for **(circle yes or no):**

Cancer……………………………………	**YES / NO**	**High Blood Pressure………………………**	**YES / NO**
Nervous Disorders……………………..…	**YES / NO**	**Hay Fever or Asthma……………………..**	**YES / NO**
Heart Disease…………………….……...	**YES / NO**	**Blood Disease……………………………….**	**YES / NO**
Muscular Disorder……………………..	**YES / NO**	**Kidney Trouble…………………………….**	**YES / NO**
Glaucoma……………………………...	**YES / NO**	**Diabetes……………………………………..**	**YES / NO**

PAST SURGICAL HISTORY: **(Please list all major surgeries)**

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HISTORY OF ILLNESSES AND CHRONIC MEDICAL PROBLEMS:

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REVIEWED BY: ____ **DATE:**_________________________________