South Shore Medical Center

Adult Patient History Form

Patient Label

Please help us get to know you better by answering the questions on both the front and back of this form.

Name	Date of Birth	E-mail Address:
Primary Care Provider:	Date of Visit	Would you like to receive information about *MyChart Online*? ❑ Yes ❑ No

Race/Ethnicity: ❑ White, Non-Hispanic ❑ Black, Non-Hispanic ❑Hispanic ❑Asian ❑ Native American ❑ Native Hawaiian and Other Pacific Islander ❑ Other:

Language Preference: ❑ English ❑ Other:

Current Health Concerns:

ALLERGIES			
Allergic to any medications?	❑ No	❑ Yes	List:
Adverse reaction to medications?	❑ No	❑ Yes	List:
Allergic to anesthesia?	❑ No	❑ Yes	List:

MEDICATIONS

List all medications you currently take including prescription medications, over-the-counter medications and herbal remedies **(please include doses if known)**

IMMUNIZATIONS
(please note date of immunization if known)

Pneumonia		Flu		Meningitis		Hepatitis A	
Tetanus		Chicken Pox		BCG		Hepatitis B	
Any Foreign Travel in the past 12 months? ❑ N ❑ Y				Any planned? ❑ N ❑ Y			

PATIENT'S MEDICAL HISTORY

❑ Alcoholism	❑ Colonoscopy	❑ Psychiatric disorder	Have you had an eye exam within the past year?
❑ Asthma	❑ Depression	❑ Seizures/Convulsions	
❑ Cancer	❑ Diabetes (sugar)	❑ Stroke	❑ Yes ❑ No If yes, where?
❑ Skin Cancer	❑ Heart Disease	❑ Thyroid Problem	
❑ Cholesterol (high)	❑ Headaches	❑ Other	
❑ Clotting disorder	❑ High blood pressure		

Please inform your provider if you have ever been told or have reason to suspect you have AIDS / HIV

PATIENT'S SURGICAL HISTORY

List type of surgery, where performed, when performed and name of surgeon

FAMILY HISTORY

Check if there is a family history of the medical problems noted below
(mother, father, siblings, grandparents, aunts, uncles or cousins)

❑ **Check here if Family History is unknown**

Problem	**Relationship To Patient**	**Maternal/ Paternal**		**Problem**	**Relationship To Patient**	**Maternal/ Paternal**	
Cancer (specify)		❑ M	❑ P	Mental Illness		❑ M	❑ P
Diabetes		❑ M	❑ P	Osteoporosis		❑ M	❑ P
Heart Disease		❑ M	❑ P	Stroke		❑ M	❑ P
High blood pressure		❑ M	❑ P	Thyroid Disease		❑ M	❑ P

FAMILY STATUS

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Son	Daughter
Alive										
Deceased										

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FOR WOMEN ONLY				
Last menses?	# pregnancies	# deliveries	# abortions	# miscarriages
Date and location of last Pap smear? (if performed outside of SSMC)		Date and location of last mammogram? (if performed outside of SSMC)		

TOBACCO USE				
Do you smoke cigarettes?	❑ Yes # packs/day # years	❑ No	❑ Quit # packs/day # years Date quit:	❑ Live with a smoker
Do you use other forms of tobacco?	❑ Pipe	❑ Snuff	❑ Cigar	❑ Chew

ALCOHOL USE				
Do you drink alcohol?	❑ Yes	# of drinks/week		In a typical week, how often do you have 5 or more alcoholic drinks on one occasion?
	❑ No	Is alcohol a concern for you now or in the past? (or other household members)	❑ No ❑ Yes	❑ Never ❑ Once/week ❑ 2-3 times/week ❑ 3+ per/week

DRUG USE		
Do you use recreational drugs?	❑ No	❑ Yes
Have you ever used IV/ injectable drugs? (even once)	❑ No	❑ Yes

SEXUALITY			
Are you sexually active?	❑ Yes	❑ No	❑ Not currently
Sexually active with:	❑ Men	❑ Women	❑ Both
Birth control method?		# of partners in last 5 yrs:	
Do you have concerns about your sex life? ❑ No ❑ Yes			

ACTIVITIES OF DAILY LIVING AND OTHER CONCERNS		
Have you had blood transfusions?	❑ No	❑ Yes
Are you exposed to hazardous materials at work?	❑ No	❑ Yes
Do you have difficulty sleeping?	❑ No	❑ Yes
Are you experiencing stress, anxiety, or depression?	❑ No	❑ Yes
Are you concerned about your weight?	❑ No	❑ Yes
Are you on a special diet?	❑ No	❑ Yes
Do you feel threatened, hurt or afraid in a relationship?	❑ No	❑ Yes
Do you or anyone in your home own a gun?	❑ No	❑ Yes
Do you exercise regularly?	❑ No	❑ Yes
If you ride a bike, do you wear a helmet?	❑ No	❑ Yes
Do you wear a seat belt?	❑ No	❑ Yes
Do you do monthly self-exams (breast/testicular)?	❑ No	❑ Yes
Do you have a carbon monoxide detector in your home?	❑ No	❑ Yes
Do you have an Advance Directive or HealthCare Proxy? *If yes and SSMC does not have a copy, please send it to us or bring it in at your next visit.*	❑ No	❑ Yes

SOCIOECONOMICS						
Occupation:						
Do you currently live in a shelter or have no steady place to sleep at night? ❑ Yes ❑No						
Education	❑ Elementary	❑ High School	❑ College	❑ Graduate School		
Marital Status	❑ Single	❑ Married	❑ Separated	❑ Divorced	❑ Widowed	❑ Cohabitating
Number of children						

FOR OFFICE USE ONLY			
Reviewed by:		Date	

♦ **Thank you for helping us to better care for you** ♦ Form #: APQ-1 Revised: 03142018