Dublin Family Care, Inc.
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ADULT COMPREHENSIVE PATIENT HISTORY

☐ **New Patient** ☐ **Established Patient**

Name: _____ **D.O.B.:**_____ **Age:** _____

Past History: *Check all that apply*

☐ Acid Reflux
☐ Alcohol or Drug problems
☐ Allergy problems
☐ Anemia
☐ Artery problems
☐ Arthritis
☐ Asthma
☐ Autoimmune disease
☐ Bleeding problems
☐ Blood clots
☐ Cancer
☐ Colitis
☐ Crohn's disease
☐ Depression, Anxiety
☐ Diabetes
☐ Emphysema
☐ Other lung disease
☐ Esophagitis, ulcers
☐ Gallstones
☐ Glaucoma
☐ Headaches
☐ Heart disease
☐ Heart valve problems
☐ High blood pressure
☐ High cholesterol
☐ Irritable bowel
☐ Kidney stones
☐ Kidney disease
☐ Liver disease
☐ Migraines
☐ Osteoporosis
☐ Recurrent skin infections
☐ Recurrent UTI
☐ Seizures
☐ Sexually transmitted infections
☐ Stroke
☐ Thyroid diseases
☐ Vein problems

☐ Other diseases not listed _____
☐ Explain any of the above if necessary _____
_____
_____
☐ Hospitalizations/Dates _____
_____

Surgery/Procedures: *Please list dates*

☐ Appendix _____
☐ Bladder suspension _____
☐ Blood vessel surgery _____
☐ Arteries
☐ Veins
☐ Dental surgery _____
☐ Eye surgery _____
☐ Gallbladder _____
☐ Heart surgery _____
☐ Bypass
☐ Heart valve surgery
☐ Angioplasty (balloon)
☐ Stents
☐ Hysterectomy _____
☐ Complete
☐ Partial (ovaries preserved)
☐ Joint replacement _____
☐ Orthopedic surgery _____
☐ Prostate surgery _____
☐ Tonsils and/or adenoids _____
☐ Tubal ligation _____
☐ Vasectomy _____

☐ Other surgery not listed above _____
☐ Significant injuries _____

Medication List: Name of medication, vitamin OTC supplements or herbal medicine	Dosage	Supplies	Times/day	Disease or Reason

Medication allergies or reactions:

Medication	Reaction	Medication	Reaction
1)		2)	
3)		4)	

Family History: Family Member	Date of Birth	Living ☑	Deceased ☑	Diseases

Diseases in the family: *Check all that apply*

☐ Arthritis
☐ Addiction problems
☐ Bleeding problems
☐ Cancer(s)
  ☐ Breast
  ☐ Colon
Cancer(s)
  ☐ Prostate
  ☐ Other: _____
☐ Depression/Anxiety
☐ Diabetes
☐ Heart disease
☐ High Blood Pressure
☐ High cholesterol
☐ Kidney disease
☐ Liver disease
☐ Mental illness
☐ Other: _____

_____

Social History:
Married? ☐ No ☐Yes Divorced? ☐ No ☐Yes Children? ☐ No ☐ Yes If yes, number of children?: _____
Family members living in the home: ☐ Mother ☐ Father ☐ Siblings ☐ Others: _____
Do you smoke?: ☐ Currently ☐ Past ☐ Never _____packs/day for _____ years. Other tobacco use? ☐ No ☐ Yes
If you do smoke, would you like information about our smoking cessation program? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes ☐ Beer ☐ Wine ☐ Liquor How many drinks per week? _____
How many servings of caffeine per day? _____ ☐ Coffee ☐ Tea ☐ Sodas ☐ Other: _____
Any illegal drug use? ☐ No ☐ Yes Type: _____
Occupation: _____ Any known occupational exposures? _____
Do you exercise regularly? ☐ No ☐ Yes How many times per week? _____ Type of exercise _____

Preventative Care:
Date of last Colon and Rectal screening: _____ ☐ Rectal exam ☐ Sigmoidoscopy ☐ Colonoscopy
Date of last eye exam: _____ Have you had a bone density (DEXA) exam? ☐ No ☐ Yes Date: _____

Immunizations:	Date	Immunizations:	Date
Tetanus		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia		Shingles	
Whooping cough		HPV	

For our FEMALE patients only:
Do you have a Gynecologist? ☐ No ☐ Yes Name: _____
Date of last PAP test: _____ Date of last mammogram: _____ Do you do breast self-exams? ☐ No ☐ Yes
Have you gone through menopause? ☐ No ☐ Yes
Menstrual or period problems: ☐ Irregular ☐ Heavy ☐ Change in frequency: _____
Number of pregnancies: _____ Number of live births: _____Vaginal _____C-section _____Miscarriages _____Abortions
Can you think of anything else that you think we should know about your health and lifestyle that is not listed here?

_____
_____
_____

Do you have Advanced Directives (Living Will, Durable Medical Power of Attorney)? ☐ No ☐ Yes