



ADULT HEALTH DATABASE

Name:	
D.O.B.:	Date:

Please review the **MEDICAL SUMMARY** you were given at check-in.
THIS IS YOUR PERMANENT MEDICAL RECORD
 Please correct any mistakes and add anything missing

Specifically, please confirm since your last health maintenance exam here:

- 1. Hospitalization? No Yes _____
- 2. Surgery? No Yes _____
- 3. Allergic reaction? No Yes _____
- 4. Major illness/accident? No Yes _____
- 5. Immunizations? No Yes _____

If not listed in your medical summary, please confirm whether you:

- 1. smoke? No Yes – how much? _____
- 2. exercise? No Yes – what type? _____ how often? _____
- 3. follow a special diet? No Yes – what? _____
- 4. drink alcohol? No Yes – how often? _____
- 5. use other drugs? No Yes _____
- 6. have an Advance Directive (living will and durable power of attorney for health care)? No Yes
 Name of Healthcare Proxy/Durable Power of Attorney for healthcare: _____
 If you have an Advance Directive (Living Will, Health Care Proxy) please provide us with a copy.
 If you would like more information, please ask.

Have you received preventative health care we are not aware of? Specifically:

Have you undergone?	Date of last	Results	Would you like to discuss?
Physical Exam			
Pap Smear			
Mammogram			
Colonoscopy			
Other test for colon cancer			
Eye Exam			
Hearing Exam			
Dental Exam			
Cholesterol Screening			
Prostate cancer blood test(PSA)			
Bone mineral density test			
Testing for HIV/AIDS/Hep C			



Evergreen

Family Health

Is there some other question you wish answered today if there is time? _____

Do you need medication refills today? YES NO

Are there any forms you request to be completed today? YES NO

Please indicate if you are having any of the following symptoms:

Constitutional	Old	New
Feeling tired		
Fever / Chills		
Recent weight change		
Eyes	Old	New
Visual changes		
Red eyes		
Ear, Nose, Throat, Mouth	Old	New
Ear pain		
Nasal congestion/Post-nasal drip		
Sore throat		
Sores in mouth		
Cardiovascular	Old	New
Chest painful or tight		
Palpitations / racing heart		
Swelling in feet or ankles		
Respiratory	Old	New
Coughing		
Wheezing		
Shortness of breath		
GI	Old	New
Decreased appetite		
Abdominal pain		
Nausea or vomiting		
Diarrhea		
Constipation		
Heartburn		
Blood in stool		
Urinary	Old	New
Pain during urination		
Frequency of urination		
Blood in urine		

Musculoskeletal	Old	New
Neck pain		
Back pain		
Joint pain		
Skin	Old	New
Skin rash		
Changing mole		
Neurologic	Old	New
Headache		
Dizziness		
Numbness		
Decrease in strength		
Psychiatric	Old	New
Sleep disturbances		
Depression		
Anxiety		
Endocrine	Old	New
Excessive sweating		
Sweating heavily at night		
Excessive thirst		
Feeling hot or cold		
Hem/Lymph	Old	New
Easy bruising		
Swelling		
Allergies	Old	New
Food allergies		
Seasonal allergies		
Gynecological (women only)	Old	New
Irregular vaginal bleeding		
Vaginal discharge		
Vaginal pain, itching or burning		
New/changing breast lump		