University HealthCare Alliance

Name ________________________

Date of Birth: __________________

Primary Care Provider: _____________________

Please arrive 30 minutes before your appointment time.
Your visit will take approximately one hour to complete.

Medications Please bring all prescription medications you are currently taking.	
Name	**Dose and Directions**

Do you currently have or have you ever had any of the following illnesses or conditions?								
C =Current P = Past								
	C	**P**		**C**	**P**		**C**	**P**
Alcohol/Drug Problem			Gallbladder disease			Osteoporosis		
Anemia			Glaucoma			Other injuries		
Anxiety/ Depression			Gout			Peripheral Artery Disease		
Arthritis			Hay fever			Pneumonia		
Asthma			Head injury			Positive Tb Test		
Atrial Fibrillation			Heart attack			Prostate Problem		
Blood clots			Heart disease			Rheumatic fever		
Cancer			Hepatitis/liver disease			Seizures		
Chicken pox			Hernia			Sexually transmitted disease		
Chronic lung disease			High blood pressure			Sleep Apnea		
Colon/bowel disease			High cholesterol			Stroke		
Dementia			Infection of uterus			Thyroid disease		
Diabetes type I or II			Kidney disease			Tuberculosis		
Emphysema						Ulcer		

Surgical and Hospitalization History with Dates

Social history		
Do you drink alcohol? □ 1-6 drinks/week □ 7-14 drinks/week □ more than 14 drinks/week	No	Yes
Do you ever drive a car when you have been drinking alcohol?	No	Yes
Do you use cocaine, heroin, speed, methamphetamines, or other drugs?	No	Yes
Have you ever injected drugs or shared needles?	No	Yes
Are you sexually active? □ with men □ with women □ with both	No	Yes
Do you have unprotected sex □, or have more than one sexual partner □?	No	Yes

FAMILY HISTORY	Deceased? Age:	Alive? Birth year	Health problems
Father			
Mother			
Brothers			
Sisters			
Paternal grandfather			
Paternal grandmother			
Maternal grandfather			
Maternal grandmother			
Children			
Extended family members with	Cancer □ Heart attacks □ Stroke □ Diabetes □		

OBGYN History: Total Pregnancies: ___ Number of deliveries: ___

Which Physician/Specialists have you seen?

Specialty	Provider	Specialty	Provider
Previous Primary Care		Orthopedist	
Audiologist		Physical Therapist	
Cardiologist		Psychiatrist	
Dietician		Pulmonologist	
Ear Nose and Throat (ENT)		Rheumatologist	
Endocrinologist		Urologist	
Gastroenterologist (GI)			
Hematologist			
OBGYN			

Over the past 2 weeks: how often have you been bothered by the following? Please circle your response.

1. Little to no pleasure in doing things	2. Feeling down, depressed or hopeless
a. Not at all b. Several days c. More than half the days d. Nearly everyday	a. Not at all b. Several days c. More than half the days d. Nearly everyday

Immunization	Date	Immunization	Date
❑ Flu Vaccine		❑ TD (Tetanus Shot)	
❑ TDAP (Whooping Cough/Tetanus)		❑ Zostavax (Shingles)	
❑ Pneumococcal PCV13		❑ HPV	
❑ Pneumococcal PPV23		❑ Other:	

Preventive Screenings To avoid duplication and to provide you with the best care possible, we would like to have information on the following items. We would like to obtain the most recent copy of the report, kindly either bring it in or let us know from where we can request a copy.
(Not all ages and genders need all the items listed below.)

Item	Date last performed	Result (if applicable)	Comments/Where can we get copy (Please include name and address)
Pap Smear			
HPV Test			
Mammogram			
Bone Density Test			
Colonoscopy			
Stool Test for Blood			
Aortic Aneurysm Screen			