Metrolina Medical Associates
Initial Visit History—Adult

Patients Name: _____ DOB: _____ Date: _____

Previous or other medical problems:

1) _____ 3) _____

2) _____ 4) _____

Have you seen any other physicians? _____ Names of other physicians: _____

Have you ever been admitted to any hospital? _____ If yes, when, where and why: _____

Have you ever had surgery? _____ If yes, please describe: _____

Have you ever had any broken bones? _____ Specify: _____

Are you allergic to any medications? _____ Specify: _____

List below any medications you are currently taking:

1) _____ 6) _____

2) _____ 7) _____

3) _____ 8) _____

4) _____ 9) _____

5) _____ 10) _____

Social History:

Do you drink caffeinated beverages? _____ How many per day? _____ Former Smoker? _____yes _____no
Do you smoke or use other tobacco products? _____ How many per day? _____ How many years? _____
Do you drink alcohol? _____ How many drinks per day? _____ Do you have a history of any drug abuse? _____

Family History (check all that apply):

High Blood Pressure	☐	Who? _____
Epilepsy	☐	Who? _____
Cancer	☐	Who? _____
Heart Attack/Angina	☐	Who? _____
Diabetes	☐	Who? _____
Asthma	☐	Who? _____
Stroke/Mini Stroke	☐	Who? _____
Thyroid	☐	Who? _____
Substance Abuse	☐	Who? _____
Mental Illness	☐	Who? _____

Preventive Healthcare:

Do you exercise? _____ How frequently? _____ Do you watch your diet? _____ Have you had your cholesterol level checked? _____ When? _____ Have you had a Tetanus shot?_____ Flu Shot? _____
Pneumovax? _____ Have your stools been checked for blood?_____
Males: Have you ever had a prostate exam? _____ PSA Level?_____ Do you perform a monthly self testicular examinations? _____
Females: Have you had a mammogram? _____ Date of last mammogram:_____ Results:_____
Do you perform breast self examinations regularly? _____

Do you have an advanced directive Living Will? _____ If not, would you like some information? _____

Please continue on next page

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Review of Systems

Please circle any which may apply to you. Use spaces to provide additional comments, if needed.

GENERAL-METABOLIC: weight change, fever, fatigue, appetite changes, temperature intolerance, cancer, diabetes, arthritis

_____

SKIN-HAIR-NAILS: swelling, rashes, changed moles, sores, itching, loss/growth of hair, change in nails, allergies/eczema

_____

HEMATOLOGIC-IMMUNOLOGIC: anemia, bleeding problems, swollen glands, thyroid

_____

BONES-JOINTS: joint pain, swelling, stiffness, bone pain, other aches

_____

NEUROMUSCULAR-PSYCHIATRIC: muscle weakness, headaches, head injury, loss of consciousness, numbness/tingling, depression, incoordination, seizures, dizziness, gait disturbance, emotional problems, sleep problems, stroke, memory loss

_____

EYES: vision problems, wear glasses/contact lenses, eye pain or redness, cataracts, glaucoma

_____

EARS: hearing problems, ringing in ears, earaches

_____

NOSE-SINUSES: nasal stuffiness or discharge, nosebleeds, sinus problems

_____

MOUTH-THROAT: dental problems, wear dentures, sores on lips/mouth/tongue, change in voice

_____

BREASTS: lumps, pain, discharge

_____

RESPIRATORY: cough, sputum, shortness of breath, wheezing, asthma, COPD/emphysema, lung disorder

_____

CARDIOVASCULAR: chest pain, heart murmur, palpitations, pain in legs while walking, blood clot, heart attack, high blood pressure

_____

GASTROINTESTINAL: swallowing difficulty, heartburn, nausea/vomiting, food intolerance, abdominal pain, jaundice, GI bleed, change in stools, diarrhea/constipation, hemorrhoids, ulcers

_____

URINARY: frequency, urination at night, increased urination, pain while urinating, urine color change, stones, incontinence, prostatic symptoms, urinary infections, kidney disease

_____

INFECTIOUS DISEASE: HIV, AIDS, Hepatitis, Tuberculosis

_____

REPRODUCTIVE:
MALE: penile sore or discharge, testicular pain or mass, STD, sexual problems
FEMALE: menstrual irregularity, LMP, vaginal discharge or sores, pregnancy complications, STD, sexual problems

_____

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**