PRIMARY CARE

Adult Medical History & Intake

A complete picture helps us care for you well. Please fill in what you know.

Today's Visit

PATIENT NAME (LAST, FIRST) _____ DATE OF BIRTH _____ TODAY'S DATE _____

REASON FOR TODAY'S VISIT / WHAT YOU'D LIKE TO FOCUS ON

_____

Past Medical History — Please check all that apply

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Diabetes (Type 1 / 2)
- ☐ Pre-diabetes
- ☐ Heart disease / heart attack
- ☐ Stroke / TIA
- ☐ Atrial fibrillation
- ☐ Asthma
- ☐ COPD / emphysema
- ☐ Sleep apnea
- ☐ Thyroid disorder
- ☐ Kidney disease
- ☐ Liver disease / hepatitis
- ☐ Cancer (specify type below)
- ☐ Anxiety
- ☐ Depression
- ☐ ADHD
- ☐ Bipolar / other mood disorder
- ☐ PTSD
- ☐ Chronic pain
- ☐ Migraine
- ☐ Acid reflux / GERD
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Autoimmune disease
- ☐ Anemia
- ☐ None of the above

OTHER CONDITIONS / SPECIFICS (CANCER TYPE, ETC.)

_____

Past Surgeries & Hospitalizations

SURGERY / PROCEDURE / REASON FOR HOSPITALIZATION	YEAR	WHERE (HOSPITAL / CLINIC)

Current Medications

Include all prescription, over-the-counter, and supplements. Bring bottles or a list to your visit if possible.

MEDICATION	DOSE	HOW OFTEN	WHY YOU TAKE IT

Allergies & Reactions

SUBSTANCE (MEDICATION, FOOD, ENVIRONMENTAL)	REACTION

☐ No known allergies

Family History — Check conditions that run in your family

CONDITION	MOTHER	FATHER	SIBLING	GRANDPARENT	OTHER / NOTES
Heart disease (before age 55 M / 65 F)	☐	☐	☐	☐	
High blood pressure	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Cancer (specify type in notes)	☐	☐	☐	☐	
Mental health (depression, anxiety, bipolar)	☐	☐	☐	☐	
ADHD	☐	☐	☐	☐	
Substance use disorder	☐	☐	☐	☐	
Sudden cardiac death (any age)	☐	☐	☐	☐	

Social History & Lifestyle

TOBACCO / NICOTINE

☐ Never used
☐ Former user (quit ___ years ago)
☐ Current cigarette smoker (___ packs/day)
☐ Current vape / e-cigarette user
☐ Smokeless tobacco / chew
☐ Exposed to secondhand smoke regularly

ALCOHOL

☐ Don't drink
☐ Occasionally / socially
☐ 1–7 drinks per week
☐ 8–14 drinks per week
☐ 15+ drinks per week
☐ Concerned about my drinking

SUBSTANCES / RECREATIONAL DRUGS

☐ Marijuana / cannabis (current)
☐ Other recreational drugs
☐ In recovery from SUD

EXERCISE & SLEEP

DAYS PER WEEK OF PHYSICAL ACTIVITY _____

TYPE / MINUTES PER SESSION _____

AVERAGE HOURS OF SLEEP PER NIGHT _____

SLEEP QUALITY (1–10) _____

DIET & CAFFEINE

SPECIAL DIET (VEGETARIAN, GLUTEN-FREE, LOW-SODIUM, ETC.) _____

CAFFEINE PER DAY (CUPS COFFEE, ENERGY DRINKS) _____

Review of Systems — Check anything you have or have had recently

GENERAL & CONSTITUTIONAL

- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Fatigue / low energy
- ☐ Fevers / chills
- ☐ Night sweats
- ☐ Loss of appetite

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Headaches
- ☐ Vision changes
- ☐ Hearing changes
- ☐ Dizziness / vertigo
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Sore throat
- ☐ Dental concerns

CARDIOVASCULAR & RESPIRATORY

- ☐ Chest pain or pressure
- ☐ Palpitations / racing heart
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Swelling in legs / ankles

GI / GU

- ☐ Heartburn / reflux
- ☐ Nausea / vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Urinary frequency / urgency
- ☐ Painful urination
- ☐ Sexual / erectile concerns

MUSCULOSKELETAL & SKIN

- ☐ Joint pain / stiffness
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Rash / new skin lesion
- ☐ Mole changes
- ☐ Hair loss

NEUROLOGIC / MENTAL HEALTH

- ☐ Numbness / tingling
- ☐ Tremor
- ☐ Memory concerns
- ☐ Anxiety
- ☐ Depression / low mood
- ☐ Trouble focusing
- ☐ Trouble sleeping
- ☐ Thoughts of self-harm
- ☐ Significant stress

Preventive Care & Screenings

LAST PHYSICAL EXAM (DATE) _____

LAST LABS / CHOLESTEROL _____

LAST COLONOSCOPY (IF APPLICABLE) _____

LAST MAMMOGRAM (IF APPLICABLE) _____

LAST PAP SMEAR (IF APPLICABLE) _____

LAST SKIN CHECK / DERMATOLOGY _____

FLU / COVID / TDAP / SHINGLES VACCINES _____

OTHER RECENT SCREENINGS _____

Anything Else You Want Us to Know?

[Free text — concerns, goals, questions you want addressed today]

PATIENT SIGNATURE _____

DATE _____