UFHealth PHYSICIANS

Internal Medicine at Medical Plaza

Patient Name: _____

Patient Data Base-Adult

Preferred Phone #: _____ MRN: _____

Information about your health is needed by your doctor to understand your medical problems and to get to know you a little better as a person. This information will remain confidential (private) and will be available to your doctor only.

Issues you wish to discuss at your first visit:

1. _____
2. _____
3. _____
4. _____
5. _____

Chronic Medical Problems

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications ☐ None

List any medications that you use often or everyday. Under dosage, list how much you are taking in either milligrams (mg) or number of pills per dose. Under how often, list how many times a day you take the medicine. Be sure to include medicines like Tylenol, aspirin, antacids, laxatives, sleeping pills, cold medicines (penicillin, sulfa, etc.) codeine, diet pills, vitamins, sedatives (nerve pills), and birth control pills.

Medications	Dosage	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Hospitalizations and Surgeries ☐ None

Year	Hospital/City and State	Reason for hospitalization OR type of surgery performed
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Medication Allergies____ ☐ None

_____

_____

Have you had any of these symptoms in the last month?

Constitution
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Fatigue
- ☐ Sweating
- ☐ Weakness

Skin
- ☐ Rash
- ☐ Itching

HENT
- ☐ Headaches
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Sore throat

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Sensitivity to light
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath laying flat
- ☐ Leg pain while walking
- ☐ Leg swelling
- ☐ Sudden shortness of breath at night

Respiratory
- ☐ Coughing
- ☐ Coughing up blood
- ☐ Sputum production
- ☐ Shortness of breath
- ☐ Wheezing

GI
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Dark, tarry stools

GU
- ☐ Pain with urination
- ☐ Urgency
- ☐ Frequency
- ☐ Blood in urine
- ☐ Flank pain
- ☐ Decreased interest in sex
- ☐ Trouble with erections
- ☐ Pain with sex

MS
- ☐ Muscle aches
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Falls

Endo/Heme/Allergies
- ☐ Easy bruise/bleed
- ☐ Environmental allergies
- ☐ Increased thirst
- ☐ Irregular periods

Neurological
- ☐ Dizziness
- ☐ Tingling
- ☐ Tremor
- ☐ Sensory change
- ☐ Speech change
- ☐ Focal weakness
- ☐ Seizures
- ☐ Loss of consciousness

Psychiatric
- ☐ Depression
- ☐ Suicidal ideas
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Nervous/Anxious
- ☐ Insomnia
- ☐ Memory loss

☐ Other _____

_____

_____

_____

_____

Health Maintenance

Testing	Year
Mammogram	_____
Colonoscopy	_____
Stool cards	_____
HIV blood test	_____
Hepatitis C blood test	_____
Cholesterol/lipid blood test	_____
Diabetes/blood sugar test	_____

Have you ever had a blood transfusion?
Date: _____

Immunizations	Year
Tetanus vaccination - TDAP	_____
Pneumococcal - Pneumovax 23	_____
Pneumococcal - Prevnar 13	_____
Flu vaccination	_____
Varicella (chickenpox) vaccine	_____
Hepatitis A or B vaccination (shots)	_____
Zostavax (shingles vaccine)	_____
Vision test (eye exam)	_____
Hearing test	_____
Urinalysis (urine test)	_____
Dental check-up	_____

Did you have all your usual childhood vaccinations?
☐ Yes ☐ No ☐ Don't know

Family History

Answer or check the appropriate item across the top row for each respective relative. Under brothers, sisters, and grandparents, list only blood relationships.

Family Member	Age	If deceased, age and cause of death	Cancer (type)	Diabetes	Heart Disease	Heart Attack	Stroke	High Blood Pressure	Arthritis	Gout	Seizures/Epilepsy	Bleeding Problems	Anemia	Sickle Cell Problems	Asthma Allergies	Tuberculosis	Alcoholism	Nervous Problems	Mental Illness	Glaucoma	Migraines	Other
Father																						
Mother																						
Brothers & Sisters																						
Other blood relatives with medical problems (Grandparents, aunts, uncles, etc.)																						

Remarks

_____

_____

Please list all healthcare providers and their specialty. (e.g. Dr. Jones - Neurology)

_____ _____

_____ _____

Social/Lifestyle History
Please answer the following questions (where indicated, check appropriate response).

1. How would you describe your race? ☐Black/African American ☐Asian
   ☐White/Caucasian ☐Multiracial ☐ Native American ☐Other _____
2. How would you describe your ethnicity?
   ☐Hispanic ☐Not Hispanic ☐Other _____
3. Are you? ☐Married/Partnered ☐Divorced ☐Separated ☐Widowed ☐Single
4. What is your sexual preference? ☐Male ☐Female ☐Both
5. Do you identify as transgender? ☐Yes ☐No ☐Don't know
   If no, you may proceed to #6. If yes, please complete the following questions.
   Do you think of yourself as: ☐Male ☐Female ☐Transgender ☐_____
   What is your current Gender Identity? ☐Male ☐Female ☐_____
   What was your gender birth? ☐Male ☐Female
   Which pronoun do you prefer we use? ☐He ☐She ☐_____
6. Do you have a specific religion or spiritual practice? ☐Yes ☐No
   If yes, please describe _____
7. Do you use alternative health providers, treatments, or remedies (ex. Homeopathy, herbs)
   ☐Yes ☐No
   If yes, please describe _____
8. Who lives in your house? _____
9. Are there any members in the household who are disabled, bedridden? ☐Yes ☐No
   If yes, who? _____
10. Are there many stresses at home? ☐Yes ☐No
    At work? ☐Yes ☐No
11. Tobacco use (check those tobacco products that you have ever used regularly)
    ☐Cigarettes ☐Pipe ☐Cigars ☐Chewing Tobacco ☐Snuff ☐None
    What is the average number of packs of cigarettes that you smoke or used to smoke per day?
    ☐None ☐Less than 1/2 ☐1/2-1 ☐1-2 ☐2 or more
    How many years have you smoked? _____
    Do you still smoke? ☐Yes ☐No If you have permanently quit, when? _____
12. Alcohol use
    Have you ever had a problem with drinking alcohol? ☐Yes ☐No
    Has anyone close to you ever thought you drank too much? ☐Yes ☐No
    How often do you drink beer, wine, whiskey? ☐ Never ☐ Once a week ☐ Several times a day
    ☐ Daily
    Number of 12-ounce cans of beer consumed a week? _____
    Number of 12-ounce glasses of wine consumed a week? _____
    Number of shots (shot= 1 1/2 ounces) of liquor consumed per week? _____
    Do you still drink? ☐Yes ☐No If you have permanently quit, when? _____

13. Do you sometimes use marijuana or other drugs socially? ☐Yes ☐No
14. Are you on a special diet? ☐Yes ☐No If yes, what kind? _____
15. Do you always use a seatbelt? ☐Yes ☐No ☐Sometimes
16. Do you text while driving? ☐Yes ☐No ☐Sometimes
17. Do you have any concerns about your weight? ☐Yes ☐No
18. How often do you exercise? ☐Never ☐Rarely ☐Once a week ☐Several times a week
    What kind of exercise? _____
19. Are you working now? ☐Yes ☐No
    What kind of work do you do?_____
    Which of the following are you exposed to at work? ☐ Excessive noise ☐ Fumes ☐ Air pollution
    ☐None/NA ☐Poisons and Chemicals ☐Crowded conditions
20. Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?
    ☐Yes ☐No
    Are you in a relationship with a person who threatens or physically hurts you? ☐ Yes ☐ No
    Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐ Yes ☐ No
21. Over the past two weeks have you been bothered by any of the following problems?
    a. Little interest or pleasure doing things? ____yes ____no
    b. Feeling down, depressed, or hopeless? ____yes ____no

_____ _____
Patient Signature Date

Reviewed by _____ _____
Provider Date