

**University of Rochester**  
**UNIVERSITY HEALTH SERVICE**  
 Preventive Care History  
 Established Patient

Name: _____		
MR#: _____		
Birthdate: _____	Age: _____	
Date: _____	Phone #: (H) _____	(W) _____ (Cell) _____

**PRESENT HEALTH CONCERNS**

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**MEDICATIONS:** (Include prescription and over-the-counter medicines, vitamins, home remedies, birth control pills, herbs, etc.)

Medication	Dose/How Often	Reason	Medication	Dose/How Often	Reason

**ALLERGIES OR REACTIONS**

Any new allergies? \_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

Any new medical problems, illnesses, surgeries, or hospitalizations since your last physical? \_\_\_\_\_

**IMMUNIZATIONS/VACCINATIONS**  
 (Indicate date of most recent.)

Hepatitis A	_____	PPD (Screen for tuberculosis)	_____
Measles	_____	Influenza (flu shot)	_____
Tetanus (Td)	_____	MMR (measles / mumps / rubella)	_____
Tetanus/Pertussis (Tdap)	_____	Varicella (chicken pox) shot or illness	_____
Hepatitis B Series	_____	Pneumococcal Vaccine	_____
		Other	_____

**HEALTH MAINTENANCE**  
 (Screening tests – Indicate date & result of most recent.)

Lipid Profile(Cholesterol)	_____	Result?	_____	Stool test for blood	_____	Result?	_____
PSA (Prostate cancer screen)	_____	Result?	_____	Mammogram	_____	Result?	_____
Sigmoidoscopy	_____	Result?	_____	Ever abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Colonoscopy	_____	Result?	_____	Details:	_____		

**OTHER HEALTH CARE PROVIDERS**  
 (Please list names of any other health care providers.)

	Name of Provider	Date of last visit
Dentist:		
Eye:		
GYN:		
Other:		

**FAMILY MEDICAL HISTORY**

Any new family history of illness since your last physical? \_\_\_\_\_

<b>SOCIAL HISTORY</b>	
<b>Marital Status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married   Spouse/Partner's name: _____ <input type="checkbox"/> Divorced   # of children/ages: _____ <input type="checkbox"/> Domestic Partner   Who lives at home with you? _____
<b>Tobacco Use:</b>	Cigarettes: <input type="checkbox"/> Never <input type="checkbox"/> Current Smoker - # of packs a day: _____ # of years: _____ Other tobacco: <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew   Are you interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Alcohol Use:</b>	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No   # of drinks/week: _____ Is alcohol use a concern for you or others? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Drug Use:</b>	Do you currently (within past 1-2 years) use any recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever used needles for recreational drug usage? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have or have you ever had abuse/addiction to drugs or alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Caffeine Intake:</b>	<input type="checkbox"/> None <input type="checkbox"/> Coffee/tea - # of cups per day: _____ <input type="checkbox"/> Sodas: _____ /day <input type="checkbox"/> Chocolate: _____ oz/day
<b>Bike Helmet:</b>	Do you use a bike helmet when you ride or roller blade? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Gun Safety:</b>	Do you have a gun in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Seat Belt:</b>	Do you use seatbelts consistently? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Smoke Detectors:</b>	Do you have a smoke detector in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Weight:</b>	Are you satisfied with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Diet:</b>	How do you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Low fat <input type="checkbox"/> Special Do you eat 5 fruits and vegetables a day? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you consume 3 servings of dairy daily or take calcium supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you take supplements/vitamins/herbs? (please list) _____ _____
<b>Exercise:</b>	Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No What kind of exercise? _____ How often? _____ How long (minutes)? _____ If you do not exercise, why? _____
<b>Other:</b>	Do you have difficulty sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No Is VIOLENCE at home a concern for you? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been ABUSED? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you ever feel unsafe in your present relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>REVIEW OF SYSTEMS</b> (Check all current problems you are having.)		
<b>General</b> <input type="checkbox"/> Change in weight <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever or chills <b>Skin</b> <input type="checkbox"/> Acne <input type="checkbox"/> Change in mole or other skin lesions <b>Head, Eyes, Ears, Nose, Throat</b> <input type="checkbox"/> Frequent nosebleeds <input type="checkbox"/> Hay fever <input type="checkbox"/> Hearing loss / Difficulty hearing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sinus problems <input type="checkbox"/> Swollen glands <input type="checkbox"/> Vision problems, eye pain, loss of vision <b>Lungs</b> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing	<b>Cardiac/Heart</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations/skipped heart beats <input type="checkbox"/> Swollen ankles <b>Gastrointestinal Issues</b> <input type="checkbox"/> Bloody or black stools <input type="checkbox"/> Change in appetite <input type="checkbox"/> Constipation <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Frequent stomach pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Persistent diarrhea <input type="checkbox"/> Recent change in bowel habits <b>Urinary</b> <input type="checkbox"/> Bladder or kidney infections <input type="checkbox"/> Leaking of urine <input type="checkbox"/> Trouble passing urine <input type="checkbox"/> Waking up at night to urinate	<b>Musculoskeletal</b> <input type="checkbox"/> Back pain <input type="checkbox"/> Joint problems <input type="checkbox"/> Tendonitis <b>Mental Health</b> <input type="checkbox"/> Abuse <input type="checkbox"/> Addictions <input type="checkbox"/> Anxiety or nervousness <input type="checkbox"/> Mood changes/depression <b>Neurology</b> <input type="checkbox"/> Dizziness, fainting <input type="checkbox"/> Frequent or severe headaches <input type="checkbox"/> Numbness or tingling sensations Other: _____ _____
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**SEXUAL HISTORY**

<b>For Men &amp; Women....</b>		<b>Comments</b>
1. Have you <i>ever been</i> in an intimate/sexual relationship?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: With a man ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
With a woman?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you <i>currently</i> in any intimate/sexual relationship?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes: With a man ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
With a woman?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. If you have had sexual intercourse/intimate relationships...		
How old were you when you became sexually active?		
Have you had intercourse/sexual activity with a new partner in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
How many sexual partners have you had in your lifetime?		
Have you had intercourse/sexual activity in the last 2 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Birth control method:		<input type="checkbox"/> None needed
5. Have you ever had any sexually transmitted infections (STIs)? (warts, herpes, chlamydia, gonorrhea, HIV, others)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Are you interested in being screened for sexually transmitted infections today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Do you have any sexual issues or other questions you would like to discuss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Have you ever had unwanted sexual activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**For Men Only....**

1. Do you have testicular pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Do you have discharge from your penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you examine your testes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Do you have any problems with sexual dysfunction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**For Women Only....**

1. Do you need a gynecological exam at this appointment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Have you reached menopause?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age:
3. Are your periods regular?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of your last period:		
Age of 1 <sup>st</sup> menses?		
Duration of menses?		
Average # days between menses?		
4. How many times have you been pregnant?		
5. How many live births? _____ Miscarriages? _____ Abortions? _____		
6. Do you examine your breasts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often?
7. Have you ever noticed a breast lump or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. When was your last Pap smear?		Results:
Ever abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details:
9. Have you noted any of the following:		
change in menstrual periods	<input type="checkbox"/> Yes <input type="checkbox"/> No	
vaginal itching or discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	
vaginal bleeding after menopause	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Have you ever experienced pain or bleeding with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Reviewed MD/NP Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_