

University of Rochester
UNIVERSITY HEALTH SERVICE

Initial Preventive
 Care Physical

Date:

Name:

MR#:

Birthdate:

Age:

Phone #: (H)

(W)

(Cell)

UHS does not discriminate with regard to differences including, but not limited to, gender identity, including transgender, marital status, psychological/physical/learning disability, race/ethnicity, religious, spiritual, or cultural identity, sexual orientation, socioeconomic status, or veteran status.

Your answers will help your provider understand your medical concerns and conditions better. This form will be filed in your UHS chart. If you are uncomfortable with any question, do not answer it. An estimate is helpful if you cannot remember specific details. Please complete all pages. THANK YOU.

Would You Like Help Filling Out This Form? Yes No (If yes, please inform the Medical Office Assistant.)

PRESENT HEALTH CONCERNS:

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

Medications or latex: _____
 Food/dust/pollen/plants: _____

PERSONAL MEDICAL HISTORY

Have you ever had: (Please check all that apply.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Head injury/concussion | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia/blood problem | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizure disorder (epilepsy) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease/palpitations /angina | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Arthritis/joint problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach or intestinal problems |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back pain/injury | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tendonitis/carpal tunnel |
| <input type="checkbox"/> Cancer/malignancy | <input type="checkbox"/> Insomnia/trouble sleeping | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Treatment for alcohol or drug use |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Tuberculosis/past positive skin test |
| <input type="checkbox"/> Chronic bronchitis/emphysema | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Urinary disorders, frequent or recurrent urinary infections |
| <input type="checkbox"/> Chronic fatigue/fibromyalgia | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Viral hepatitis, jaundice (turning yellow) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine/recurrent headache | <input type="checkbox"/> Vision loss |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Digestive troubles | <input type="checkbox"/> Obesity/overweight | _____ |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Pain, chronic | _____ |
| <input type="checkbox"/> Eating disorder, anorexia nervosa, bulimia | <input type="checkbox"/> Pelvic Infection | _____ |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Phlebitis/blood clot | _____ |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Polio | _____ |
| <input type="checkbox"/> Hay fever/seasonal allergies | <input type="checkbox"/> Prostatitis | _____ |

SURGERIES/HOSPITALIZATIONS (List All)

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

(List names of any other health care provider.)

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

FAMILY MEDICAL HISTORY

(Indicate the current status of your immediate family members.)

	Alive	Deceased	Age (now or at death)	Comments/Cause of Death
Mother:				
Father:				
Sister(s):	#			
Brother(s):	#			
Daughter(s):	#			
Son(s):	#			

Indicate with a ✓ family members who have had any of the following conditions.

Medical Condition	Mother	Father	Sister	Brother	Daughter	Son	Mother's Mother	Mother's Father	Father's Mother	Father's Father
Bleeding disorders/blood clots										
Cancer (type)										
Diabetes										
Glaucoma										
Heart Disease										
Mental Illness										
Stroke										
Thyroid Disease										
Other significant illness										

SOCIAL HISTORY

Occupation: _____ Employer: _____
Years of education/highest degree: _____

Marital Status: Single Married Spouse/Partner's name: _____
 Divorced # of children/ages: _____
 Domestic Partner Who lives at home with you? _____

Tobacco Use: Cigarettes: Never Current Smoker - # of packs a day: _____ # of years: _____
Other tobacco: Pipe Cigar Snuff Chew Are you interested in quitting? Yes No

Alcohol Use: Do you drink alcohol? Yes No # of drinks/week: _____
Is alcohol use a concern for you or others? Yes No

Drug Use: Do you currently (within past 1-2 years) use any recreational drugs? Yes No
Have you ever used needles for recreational drug usage? Yes No
Do you have or have you ever had abuse/addiction to drugs or alcohol? Yes No

Caffeine Intake: None
 Coffee/tea - # of cups per day: _____ Sodas: _____ /day Chocolate: _____ oz/day

Bike Helmet: Do you use a bike helmet when you ride or roller blade? Yes No

Gun Safety: Do you have a gun in your home? Yes No

Seat Belt: Do you use seatbelts consistently? Yes No

Smoke Detectors: Do you have a smoke detector in your home? Yes No

Weight: Are you satisfied with your weight? Yes No

Diet: How do you rate your diet? Good Fair Poor Low fat Special
Do you eat 5 fruits and vegetables a day? Yes No
Do you consume 3 servings of dairy daily or take calcium supplements? Yes No
Do you take supplements/vitamins/herbs? (please list) _____

Exercise: Do you exercise regularly? Yes No
What kind of exercise? _____ How often? _____
How long (minutes)? _____ If you do not exercise, why? _____

Other: Do you have difficulty sleeping?
Is VIOLENCE at home a concern for you? Yes No
Have you ever been ABUSED? Yes No
Do you ever feel unsafe in your present relationship? Yes No

REVIEW OF SYSTEMS

(Check all current problems you are having.)

General

- Change in weight
- Fatigue
- Fever or chills

Skin

- Acne
- Change in mole or other skin lesions

Head, Eyes, Ears, Nose, Throat

- Frequent nosebleeds
- Hay fever
- Hearing loss / Difficulty hearing
- Hoarseness
- Sinus problems
- Swollen glands
- Vision problems, eye pain, loss of vision

Lungs

- Cough
- Shortness of breath
- Wheezing

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Cardiac/Heart

- Chest Pain
- Palpitations/skipped heart beats
- Swollen ankles

Gastrointestinal Issues

- Bloody or black stools
- Change in appetite
- Constipation
- Difficulty swallowing
- Frequent stomach pain
- Heartburn
- Persistent diarrhea
- Recent change in bowel habits

Urinary

- Bladder or kidney infections
- Leaking of urine
- Trouble passing urine
- Waking up at night to urinate

Musculoskeletal

- Back pain
- Joint problems
- Tendonitis

Mental Health

- Abuse
- Addictions
- Anxiety or nervousness
- Mood changes/depression

Neurology

- Dizziness, fainting
- Frequent or severe headaches
- Numbness or tingling sensations

Other: _____

SEXUAL HISTORY

For Men & Women....

Comments

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?	<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	

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 st menses?		
Duration of menses?		
Average number of 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:** _____