University of Rochester **UNIVERSITY HEALTH SERVICE** Initial Preventive Care Physical	Name: Birthdate: Age: Phone #: (H) (W) (Cell)
Date:	

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.

The goal of a preventive care visit is to detect or prevent serious medical problems at the earliest opportunity. We do this by asking you for information about your health behaviors and family history, doing a physical exam, ordering certain tests and immunizations, and giving you advice on how you can improve your health and well-being.

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.)

Do you have a chosen/preferred name? _____

Pronouns: _____

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)

- ☐ Acne
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Anxiety or nervousness
- ☐ Back pain/injury
- ☐ Blood Disorder
- ☐ Cancer/malignancy
- ☐ Carpal Tunnel
- ☐ Cerebral palsy
- ☐ Chicken pox
- ☐ Chronic bronchitis
- ☐ Chronic fatigue/
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive troubles
- ☐ Dizziness/fainting
- ☐ emphysema
- ☐ Eating disorder, anorexia nervosa, bulimia
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gallbladder disease
- ☐ Hay fever/seasonal allergies
- ☐ Head injury/concussion
- ☐ Hearing Loss
- ☐ Heart disease/palpitations/angina
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney problems
- ☐ Learning disability
- ☐ Liver disease
- ☐ Menstrual problems
- ☐ Migraine/recurrent headache
- ☐ Multiple sclerosis
- ☐ Obesity/overweight
- ☐ Pain, chronic
- ☐ Pelvic Infection
- ☐ Phlebitis/blood clot
- ☐ Polio
- ☐ Prostate Problems:
- ☐ Rheumatic fever
- ☐ Seizure disorder (epilepsy)
- ☐ Skin disorder
- ☐ Stomach or intestinal problems
- ☐ Stroke
- ☐ Tendonitis
- ☐ Thyroid disorder
- ☐ Treatment for alcohol or drug use
- ☐ Past Positive Tuberculin Skin Test
- ☐ Urinary disorders/infections
- ☐ Viral hepatitis
- ☐ Vision loss
- ☐ Other (specify):_____

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		Pneumoccoccal Vaccine	
HPV (under age 26)		Shingrix	
		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? ☐ Yes ☐ 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										
Hypertension										
Mental Illness										
Stroke										
Thyroid Disease										
Other significant illness										

Social History

Occupation: _____ Employer: _____

Years of education/highest degree:

Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner Spouse/Partner's name: _____ # of children/ages: _____ Who lives at home with you? _____
Tobacco Use:	Cigarettes: ☐ Never ☐ Current Smoker - # of packs a day: _____ # of years: _____ Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape 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 ☐ Sodas - #of cups/day: _____ ☐ Coffee/tea - # of cups per day: _____ ☐ Chocolate – oz./day: _____
Eating Habits:	Are you satisfied with your weight? ☐ Yes ☐ No How do you describe your eating habits? ☐ Good ☐ Fair ☐ Poor ☐ Low fat ☐ Special Do you eat at least 5 servings of fruits and/or vegetables a day? ☐ Yes ☐ No Do you consume at least 3 servings of dairy daily or take calcium/vitamin D supplement? ☐Yes ☐No Do you take supplements/vitamins/herbs? (please list) _____
Physical Activity:	On average, how many days per week do you engage in moderate to vigorous physical activity, such as brisk walking? _____ On average, how many minutes do you engage in physical activity at this level? _____ How many days a week do you perform muscle strengthening exercises, such as bodyweight exercises or resistance training?
Other:	Do you use a helmet when you ride a bike, roller blade, ski or participate in other sport where use of helmet recommended? ☐ Yes ☐ No Do you have a gun in your home? ☐ Yes ☐ No Is it stored safely? ☐ Yes ☐ No Do you use seatbelts consistently, even when a passenger? ☐ Yes ☐ No Do you have a smoke detector in your home? ☐ Yes ☐ No Carbon monoxide meter? ☐ Yes ☐ No Do you have difficulty sleeping? Is VIOLENCE at home or at the workplace a concern for you? ☐ Yes ☐ No vs. do you feel safe at home/ at your job? 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

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 HEALTH
Please answer as much as you feel comfortable sharing.

For Every Person		**Comments**
1. What is your sexual orientation (check all that apply)? ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Pansexual ☐ Asexual ☐ My orientation is not listed here _____		
2. Have you had sex of any kind?	☐ Yes ☐ No	
3. Have you ever had unwanted sex?	☐ Yes ☐ No	
4. Have you experienced dissatisfaction, pain or bleeding with sex?	☐ Yes ☐ No	
5. Do you have any sexual issues or questions you would like to discuss?	☐ Yes ☐ No	
6. Are you interested in being screened for sexually transmitted infections today?	☐ Yes ☐ No	

Persons with Penises/Testicles		**Comments**
1. Do you have testicular pain or swelling?	☐ Yes ☐ No	
2. Do you have discharge from your penis?	☐ Yes ☐ No	
3. Do you examine your testicles?	☐ Yes ☐ No	

For Persons with Vaginas/Uteruses/Ovaries		**Comments**
1. When was your last Pap smear? Results:		
Have you ever been told your PAP results were abnormal?	☐ Yes ☐ No	Details:
2. Have you reached menopause? If yes, skip to question 5.	☐ Yes ☐ No	Age:
3. Birth control method, if applicable.		
4. Are your periods regular?	☐ Yes ☐ No	
Date of your last period:		
Age of 1st period?		
How long do your periods usually last?		
What is the average # days between your periods?		
Do you experience bleeding in between periods?	☐ Yes ☐ No	
Do you experience painful or heavy periods?	☐ Yes ☐ No	
Have you seen changes with your periods?	☐ Yes ☐ No	
5. How many times have you been pregnant?		
6. How many live births? _____ Miscarriages? _____ Abortions? _____		
7. Have you noted any of the following:		
Leaking of urine	☐ Yes ☐ No	
Vaginal itching or discharge	☐ Yes ☐ No	
Vaginal bleeding after menopause	☐ Yes ☐ No	

For Persons with Breasts		**Comments**
1. Do you examine your breasts/chest?	☐ Yes ☐ No	If yes, how often?
2. Have you ever noticed a breast/chest lump or discharge?	☐ Yes ☐ No	

Reviewed MD/DO/NP Signature: _____ **Date:** _____