University of Rochester
UNIVERSITY HEALTH SERVICE
Preventive Care History
Established Patient

Date:

Name:
Birthdate: Age:
Phone #: (H) (W)
Phone # (cell)

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

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
Measles
Tetanus (Td)
Tetanus/Pertussis (Tdap)
Hepatitis B Series
HPV (under age 26)
PPD (Screen for tuberculosis)
Influenza (flu shot)
MMR (measles / mumps / rubella)
Varicella (chicken pox) shot or illness
Pneumococcal Vaccine
Other

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

Lipid Profile(Cholesterol) Result?
PSA (Prostate cancer screen) Result?
Sigmoidoscopy Result?
Colonoscopy Result?
Stool test for blood Result?
Mammogram Result?
Ever abnormal? ❑ Yes ❑ No
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?

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 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: # cups/day _____ ❑ Coffee/tea - # of cups per 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 Is it stored safely? ❑ 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? ❑ Yes ❑ No 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

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 *ever been* in an intimate/sexual relationship?	❑ Yes ❑ No	
If yes: With a man?	❑ Yes ❑ No	
With a woman?	❑ Yes ❑ No	
2. Are you *currently* in any intimate/sexual relationship?	❑ Yes ❑ No	
If yes: With a man ?	❑ Yes ❑ No	
With a woman?	❑ Yes ❑ 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?	❑ Yes ❑ No	
How many sexual partners have you had in your lifetime?		
Have you had intercourse/sexual activity in the last 2 months?	❑ Yes ❑ No	
4. Birth control method:		❑ None needed
5. Have you ever had any sexually transmitted infections (STIs)? (warts, herpes, chlamydia, gonorrhea, HIV, others)	❑ Yes ❑ No	
6. Are you interested in being screened for sexually transmitted infections today?	❑ Yes ❑ No	
7. Do you have any sexual issues or other questions you would like to discuss?	❑ Yes ❑ No	
8. Have you ever had unwanted sexual activity?	❑ Yes ❑ No	

For Men Only….

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 testes?	❑ Yes ❑ No	
4. Do you have any problems with sexual dysfunction?	❑ Yes ❑ No	

For Women Only….

1. Do you need a gynecological exam at this appointment?	❑ Yes ❑ No	
2. Have you reached menopause?	❑ Yes ❑ No	Age:
3. Are your periods regular?	❑ Yes ❑ No	
Date of your last period:		
Age of 1st 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?	❑ Yes ❑ No	If yes, how often?
7. Have you ever noticed a breast lump or discharge?	❑ Yes ❑ No	
8. When was your last Pap smear?		Results:
Ever abnormal?	❑ Yes ❑ No	Details:
9. Have you noted any of the following:		
change in menstrual periods	❑ Yes ❑ No	
vaginal itching or discharge	❑ Yes ❑ No	
vaginal bleeding after menopause	❑ Yes ❑ No	
10. Have you ever experienced pain or bleeding with intercourse?	❑ Yes ❑ No	

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