Adult Medical Services PC
8167 Sheridan Dr Suite 100, Williamsville, NY 14221
Office: (716) 276-8726
Fax: (716) 276-8730

Name **Date of Birth** **Date**

Please fill out all pages of this form to the best of your ability. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any questions, you may leave the answer blank. Thank you!

Where were you getting your care before? _____

Review of Systems: Please mark the box and/or circle any persistent symptoms you have had in the past few months.

General
__Unexplained weight loss/gain
__Unexplained weakness/fatigue
__Fall asleep during the day when sitting

Skin
__New or change in mole
__Rash/Itching

Breast
__Breast lump/pain/nipple discharge

Ears/Nose/Throat
__Nosebleeds
__Frequent sore throat

Eyes
__Change in vision/Eye pain

Cardiovascular
__Chest pain/Discomfort
__Palpitations (fast/irregular heartbeat)

Respiratory
__Cough/Wheeze
__Loud snoring/Altered breathing during sleep
__Short of breath with exertion

Gastrointestinal
__Heartburn/Reflux
__Indigestion
__Blood or change in bowel movement
__Constipation

Genitourinary
__Leaking urine
__Blood in urine
__Nighttime urination
__Frequent urination
__Discharge: penis/vagina

Musculoskeletal
__Neck/Back pain
__Muscle/Joint pain

Hematologic/Lymphatic
__Swollen glands
__Easy bruising

Neurological
__Headache
__Memory Loss
__Fainting
__Dizziness
__Numbness/Tingling
__Unsteady gait
__Frequent falls
__No problems

Allergies/Immune
__Hay fever/Allergies
__Frequent infections
__No problems

Psychiatric
__Anxiety/Stress
__Sleep problems
__Lack of concentration
__No problems

Women Only
__Pre-menstrual symptoms (Bloating, cramps, irritability)
__Problem w/ menstrual period
__Hot flashes/Night sweats

MEDICATIONS: Please list (or attach your own printed list) of all prescription and non-prescription medications including vitamins, home remedies, birth control, herbs, inhalers, etc.

□ **NO CURRENT MEDICATIONS**

Mediation	**Dose (e.g., mg/pill)**	**How many times per day?**

Allergies or intolerances to medications (Include reaction to medication):

_____

_____

□ **No Allergies**

SOCIAL HISTORY

Occupation (or prior occupation):_____retired/unemployed/leave of absence/disabled

Employer:_____ Years of education or highest degree:_____

Marital Status (Circle one): Single/Partner/Married/Divorced/Widowed/Other:_____

Spouse/Partner's Name:_____ Number of children:____ Ages if under 18:_____

Number of Grandchildren:_____ Number of Great Grandchildren:_____

Who lives at home with you?_____

Leisure activities, hobbies, group involvement, volunteer work, recent travel:

_____

Tobacco Use:

Smoke Cigarettes: ☐ Yes ☐ Quit ☐ Never

Quit Date: _____

How many years did you smoke? ____

Approx. how many packs a day did you smoke? _____

Current Smoker: Packs/Day: _____

Number of years: _____

Other tobacco:

☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No

# of Drinks/Week: ____ ☐ Beer ☐ Wine ☐ Liquor

Drug Use:

Do you use marijuana or recreational drugs?

☐ Yes ☐ No

Have you ever used needles to inject drugs?

☐ Yes ☐ No

Sexual Activity:

Sexually active? ☐ Yes ☐ No

Sexual partner(s) is/are/have been:

☐ Male ☐ Female

Birth Control Method (Circle all that apply):

Condom, Pill, Diaphragm, IUD, Vasectomy, Other: _____

☐ None needed

Exercise:

Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise?

_____

_____

How long (Minutes): _____

How often: _____

Diet:

How would you rate your diet?

☐ Good ☐ Fair ☐ Poor

Would you like advice on your diet? ☐ Yes ☐ No

Safety:

Do you use a bike helmet? ☐ No bike ☐ Yes ☐ No

Do you use a seatbelt consistently? ☐ Yes ☐ No

Does your home have a working smoke detector? ☐ Yes ☐ No

If you have guns in your home, are they locked up properly? ☐ Not Applicable ☐ Yes ☐ No

Is violence at home a concern for you?

☐ Yes ☐ No

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)?

(If yes, circle all that apply) ☐ No

Personal Medical History: Please check any current or past medical history below. ☐ **NONE**

Condition	Current	Past	Comment
Abdominal Aortic Aneurysm			
AIDS			
Alcohol/Drug Abuse			
Allergies (Hay Fever)			
Alzheimer's			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
ADHD			
Bipolar Disorder			
Bladder/Kidney Problems			
Bleeding Disorder			
Blood-Clot (Leg)			
Blood-Clot (Lung)			
Breast Lump (Benign)			
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Prostate Cancer			
Cancer (Other):			
Carotid Artery Stenosis			
Cataracts			
Chickenpox			
Colon Polyps			
Coronary Artery Disease			
Congestive Heart Failure			
Crohn's Disease			
Dementia			
Depression			
Diabetes (Adult Onset)			
Diabetes (Childhood Onset)			
Diverticulitis			
Diverticulosis			
Emphysema			
Endometriosis			
Epilepsy			
Fibromyalgia			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions			
Heart Attack			

Personal Medical History (Continued) Condition	Current	Past	Comment
Hepatitis A			
Hepatitis B			
Hepatitis C			
Hepatitis (Other)			
HIV			
Hearing Loss			
High Blood Pressure			
High Cholesterol			
Hemophilia			
Hernia (Specify type)			
Irritable Bowel Syndrome (IBS)			
Kidney Disease/Failure			
Liver disease			
Leukemia			
Lymphoma			
Lupus			
Migraine Headaches			
Muscle Disorder			
Non-Hodgkins Lymphoma			
Osteoporosis			
Parkinson’s			
Peripheral Vascular Disease			
Prostate (Enlarged)			
Prostate (Nodule)			
Skin Condition (Please specify)			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive)/Hyperthyroidism			
Thyroid Low (Underactive)/Hypothyroidism			
Other:			

SURGICAL HISTORY: Please check off any procedures/surgeries & list any abnormal findings/complications.

□ **NONE**

Surgical Procedures	Yes	Year	Comments
Abdominal Surgery			
Appendectomy (Appendix Removal)			
Back Surgery			
Biopsy (Specify Location)			
Breast Biopsy			Circle: Right/Left/Both
Breast Surgery			Circle: Right/Left/Both
Cataract			
Colonoscopy			
Coronary Bypass			
Coronary Stent			
Dilation & Curettage (D&C)			
EGD (Stomach Endoscopy)			
Gastric Bypass			
Gallbladder Removal			Circle: Laparoscopic
Hernia Repair			
Hemorrhoidectomy			
Hip Surgery			Circle: Right/Left/Both
Hysterectomy (Partial – Ovaries left)			Circle: Laparoscopic/Vaginal/Abdominal
Hysterectomy (Total)			Circle: Laparoscopic/Vaginal/Abdominal
LEEP (Cervix Surgery)			
Kidney Stone Removal			
Knee Surgery			Circle: Right/Left/Both
Mastectomy			
Neck Surgery			
Tubal Ligation			
Ovary Removal			Circle: Right/Left/Both
Prostatectomy (Prostate Removal)			
Sinus Surgery			
Vasectomy			
Wisdom Teeth Removal			
Other:			

FAMILY HISTORY – Indicate which relative has had the following medical conditions (Parents and siblings are most important).

Adopted: ☐ Yes ☐ No - If yes and you do not know your family history, please skip this section.

Medical Condition	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No Significant History										
Alcoholism/Drug Abuse										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Breast Cancer										
Colon Cancer										
Ovarian Cancer										
Prostate Cancer										
Cancer (Other):										
Colon Polyp										
Coronary Artery Disease										
Depression/Suicide/Anxiety										
Diabetes (Adult Onset)										
Diabetes (Childhood Onset)										
Emphysema										
COPD										
Genetic Disorder (Specify)										
Glaucoma										
Congestive Heart Failure (CHF)										
Heart Disease										
Hepatitis B or C										
High Blood Pressure										
High Cholesterol										
Hips Fracture										
Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis										
Other (Specify)										