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

Name: _____ Date of birth:____/_____/_____

Address: _____

Mobile phone: (____)_____-_____ Phone carrier: _____

Home phone: (____)_____-_____ Email address: _____

Emergency contact name: _____ Phone:(___)____-_____

Primary language: _____

Race: ☐ Caucasian ☐ Black/African American ☐ Asian ☐ American Indian
☐ Native Hawaiian ☐ Other _____

Where were you getting your care before? _____

What is the primary reason for your visit today? (Please describe in detail):

_____
_____

Patient Medical History: Please check all that apply to you

☐ Asthma/COPD ☐ Depression/Anxiety ☐ Hypertension ☐ Thyroid
☐ Autoimmune Disease ☐ Diabetes ☐ Kidney Disease ☐ Other_____
☐ Arthritis ☐ Gastrointestinal Disease ☐ Sleep Apnea ☐ None
☐ Cancer ☐ Heart Disease ☐ Stroke

Please describe:

_____
_____
_____

Previous Surgeries: Please list any surgeries with the approximate date

_____

_____

_____

List of Specialists: ex: cardiology, endocrinology, urology, orthopedic, etc…

_____

_____

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**

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

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

_____

_____

Preventative Care:

Last Mammogram _____(date and location of test)

Last Pap Smear_____(date and location of test)

Last Colonoscopy_____(date and location of test)

Family History: Do you know of any immediate relative who has or had:

☐ Asthma ☐ Diabetes ☐ Mental health disorder ☐ Thyroid
☐ Aneurysm ☐ Heart problems ☐ Multiple Sclerosis ☐ Other_____
☐ Autoimmune Disease ☐ High blood pressure ☐ Psychiatric Disease ☐ None
☐ Cancer ☐ Kidney Disease ☐ Stroke

Please describe (include condition and family member):

_____
_____
_____

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 ☐ Vape

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 Orientation:

☐ Straight/Heterosexual ☐ Bisexual

☐ Lesbian/Gay/Homosexual

☐ Other _____ ☐ Decline to specify

Gender Identity:

☐ Male ☐ Female

☐ Transgender Male ☐ Transgender Female

☐ Other _____

☐ Declined to specify

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