

MIU Adult Information

Patient Name: _____

Chart # / Office: _____

Home Phone: _____

Referring Physician: _____

Work Phone: _____

Date: _____

PLEASE ANSWER ALL QUESTIONS:

What is your reason for today's visit? _____

GENERAL REVIEW OF SYSTEMS: Are you currently having any of the following?

- | | | |
|-------------------------------------|--------------------------------|------------------------------|
| Hearing Problems? Yes ___ No ___ | Fevers? Yes ___ No ___ | Constipation? Yes ___ No ___ |
| Painful Urination? Yes ___ No ___ | Back Ache? Yes ___ No ___ | Chest Pain? Yes ___ No ___ |
| Seasonal Allergies? Yes ___ No ___ | Skin Rashes? Yes ___ No ___ | Depression? Yes ___ No ___ |
| Bleeding Tendencies? Yes ___ No ___ | Headache? Yes ___ No ___ | Hot Flashes? Yes ___ No ___ |
| Shortness of Breath? Yes ___ No ___ | Blurred Vision? Yes ___ No ___ | |

Please describe any problem above or any other problem not mentioned: _____

MEDICATIONS:

Are you **CURRENTLY** taking any medications? If yes, please list: _____

Please list any ***allergies*** to medications: _____

What was the reaction? _____

Please see list; Attached, Dated _____ & Signed _____

Do you take Aspirin or Aspirin-like products? Yes ___ No ___

Do you take Blood Thinners? Yes ___ No ___ If yes what Blood Thinner? _____

Do you require medications or antibiotics before procedures? Yes ___ No ___

HISTORY:

Past Medical / Family / Social History: (Please Check all that apply and provide information below)

- | | | |
|--|-------------------------------|--------------------------|
| <u>YOUR PERSONAL</u> medical history: | Cancer Yes ___ No ___ | Stroke Yes ___ No ___ |
| High blood Pressure Yes ___ No ___ | Heart Disease Yes ___ No ___ | Diabetes Yes ___ No ___ |
| Heart Valve problems Yes ___ No ___ | Kidney Disease Yes ___ No ___ | Glaucoma Yes ___ No ___ |
| HIV Exposure Yes ___ No ___ | Lung Problems Yes ___ No ___ | Hepatitis Yes ___ No ___ |

FAMILY medical history; have any family members had:

Cancer Yes ___ No ___ Heart Problems Yes ___ No ___ Kidney Disease Yes ___ No ___ Diabetes Yes ___ No ___

YOUR Social History; Do **YOU**: Smoke Yes ___ No ___

Drink Alcohol Yes ___ No ___

Use Drugs Yes ___ No ___

Have Unprotected Sexual Relations Yes ___ No ___

MEDICAL PROBLEM / SURGICAL HISTORY:

Please list & note dates of your surgeries / hospitalizations.

Major Medical Problems

Past Surgeries / Hospitalizations

Patient Signature: _____

Physician Signature: _____

Form Completed By: _____

Relation _____ Date ____/____/____

OFFICE USE ONLY

ROS CHANGES:

Constitutional _____	Cardiovascular _____	Respiratory _____
Skin _____	Hem/Lymph _____	Psych _____
Neuro _____	Eyes _____	GI _____
ENT _____	Musc/Skel _____	Endo _____
	Allergy/Imm _____	

PFSH: Meds: _____ Other: _____

PERSONAL: _____

FAMILY: _____

SOCIAL: _____

UPDATED BY: _____ **Date** ____ / ____ / ____

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PFSH: Meds: _____ Other: _____

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UPDATED BY: _____ **Date** ____ / ____ / ____

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PFSH: Meds: _____ Other: _____

PERSONAL: _____

FAMILY: _____

SOCIAL: _____

UPDATED BY: _____ **Date** ____ / ____ / ____