ADULT DATABASE

To Our Patients,

The more we know about you and your family, the better medical care we can provide you. This information will be confidential and released only by your written request.

Sincerely, Penny Hahn M.D.

Name: ____

Birthdate: ___/___/___ **Sex:** **M** **F** **Marital Status:** **S** **M** **D** **W**

Phone: __________________ **S.S. #:** _____________________ **Occupation:** ________________________

Names and ages of household members

____

Phone: _______________ **Address:**____

Reason you came to the doctor today? ____

Allergies (medication, foods, plants) Please note type of reaction for each listed.

____

____

Chronic medical conditions (asthma, high blood pressure, etc)

____

Current Medications (prescriptions, patches, drops, birth control pills, O.T.C. medications)

1. ____________________________ 4. ____________________________ 7. ____________________________

2. ____________________________ 5. ____________________________ 8. ____________________________

3. ____________________________ 6. ____________________________ 9. ____________________________

Surgeries, Hospitalization, Serious Illnesses ____

Last Physician ____

Please Estimate How Much

Beer/Wine: ___________________ **Cigarettes:** ___________________________

Coffee/ tea: ___________________ **Chewing tobacco/ snuff:** _______________

Soft drinks: ___________________ **Pipe:** ________________________________

Mixed drinks: _________________ **Cigars:** ______________________________

Are you right/left handed ________________________ **Do you use seatbelts?** **Yes** **No**

Date of last dental visit __________________________ **Do you exercise regularly?** **Yes** **No**

Date of last cholesterol test _______________________ **Have you ever used drugs?** **Yes** **No**

Date of pneumovax _____________________________ **Are you sexually active?** **Yes** **No**

Date of last tetanus shot _________________________ **Are you at risk for AIDS?** **Yes** **No**

Signature ____ **Date**_____________________________

Medical Problems of Blood Relatives (These family medical problems may affect your likelihood of developing certain health conditions.) Please write what relative has the problem.

Tuberculosis(TB) ________________________________
Smoke, Dip, Chew _______________________________
High Blood Pressure ______________________________
Heart Disease/Attacks _____________________________
High Cholesterol _________________________________
Bleeding Problems _______________________________
Stroke ____
Diabetes ______________________________________
Cancer _______________________________________
Anemia _______________________________________

Migraine Headaches __________________________________
Epilepsy, Seizures ____________________________________
Alcoholism, Drug Use _________________________________
Mental Illness/ Learning Problems ______________________
Lung Disease ____
Allergies/Asthma _____________________________________
Kidney Disease _______________________________________
Arthritis ____
Glaucoma ____
Thyroid Problems ____________________________________

SYMPTOM REVIEW (Circle **Y** for any symptoms **YOU** are having **NOW**)

Chills, fever/night sweats	Y	N	Jaundice/hepatitis	Y	N	Poor sleep	Y	N
Wear glasses or contacts	Y	N	Black or bloody stools	Y	N	Fatigue	Y	N
Blurry vision	Y	N	Hemorrhoids	Y	N	Frequent headaches	Y	N
Eye pain or itching	Y	N	Hernia	Y	N	Depressed/lonely	Y	N
Frequent ear infections	Y	N	Painful urination	Y	N	Irritability	Y	N
Hearing problems	Y	N	Frequent urination	Y	N	Poor memory/concentration	Y	N
Nosebleeds	Y	N	Night time urination	Y	N	Unmotivated	Y	N
Tooth/gum pain	Y	N	Decreased urinary force	Y	N	Poor sex drive	Y	N
Frequent sore throat	Y	N	Loss of urine	Y	N	Cry frequently	Y	N
Wear dentures	Y	N	Blood in urine	Y	N	Nervousness	Y	N
Frequent coughing	Y	N	Kidney stones	Y	N	Weight change	Y	N
Coughing up blood	Y	N	Venereal disease	Y	N	Poor appetite	Y	N
Shortness of breath	Y	N	Muscle/joint pain	Y	N	Thoughts of suicide	Y	N
Wheezing/asthma	Y	N	Leg pain while walking	Y	N	Family problems	Y	N
Tuberculosis	Y	N	Swollen joints	Y	N	**Men only**		
Racing/irregular heartbeat	Y	N	Back pain	Y	N	Discharge from penis	Y	N
Chest pain	Y	N	Gout	Y	N	Problem with erection	Y	N
Swelling of feet/ankles	Y	N	Diabetes	Y	N	Lump on testicles	Y	N
Frequent abdominal pain	Y	N	Anemia	Y	N	Prostate trouble	Y	N
Trouble swallowing	Y	N	Varicose veins	Y	N	**Women Only**		
Heartburn	Y	N	Psoriasis	Y	N	Lump in breast	Y	N
Nausea/vomiting	Y	N	Other skin problems	Y	N	Nipple discharge	Y	N
Vomiting blood	Y	N	Overweight	Y	N	Vaginal discharge	Y	N
Frequent constipation	Y	N	Easy bleeding/bruising	Y	N	Tubal infection (PID)	Y	N
Frequent diarrhea	Y	N	Dizzy/light headed	Y	N	Painful periods	Y	N
Exposure to HIV/AIDS	Y	N	Tremor/shaking	Y	N	Spotting between periods/after menopause	Y	N
TB or Hepatitis exposure	Y	N	Hair loss	Y	N	Pain with sex	Y	N
						Hot flash/menopause	Y	N

Women Only
Age when your period started _____________ Date of last period (1st day) _____________ Date of last pap/pelvic exam _________________

Have you had an abnormal pap? Y N, if yes, when? ______________, Have you had a breast lump? Y N, If yes, when? _____________

Do you have a history of breast cancer? Y N, Has any blood relative had breast cancer? Y N, If yes, when? ______________________

Are your periods regular Y N, Is cramping a problem Y N, Is excessively heavy flow a problem? Y N

Are you sexually active Y N, Type of birth control used ____

Number of Pregnancies ______________, Miscarriages ______________, Abortions ______________, Twins ______________

Thank you.

SIGNATURE: ____ DATE: ____