PINNACLE
Family Health Care

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New Patient Sick Visit (Adult)

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Date of Birth: _____ **Biological Sex:** ☐ **Male** ☐ **Female**

REASON FOR YOUR VISIT TODAY: _____

_____

Allergies & Reactions: _____

_____

Are you currently experiencing any of the following problems or symptoms?

- ☐ Fever or chills
- ☐ Poor Appetite
- ☐ Weight Loss
- ☐ Headaches
- ☐ Trouble swallowing
- ☐ Mouth Sores
- ☐ Runny Nose
- ☐ Snoring
- ☐ Decreased hearing/ringing in ears
- ☐ Ear Pain
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling
- ☐ Nausea or vomiting
- ☐ Heartburn or indigestion
- ☐ Abdominal pain
- ☐ Diarrhea or constipation
- ☐ Blood in the stool or black stools
- ☐ Rectal pain
- ☐ Change in bowel movements
- ☐ Gas or belching
- ☐ Involuntary loss of urine
- ☐ Pain/burning with urination
- ☐ Blood in Urine
- ☐ Neck or back pain
- ☐ Pain, swelling, or stiffness in joints
- ☐ Muscle pain
- ☐ Dizziness
- ☐ Weakness
- ☐ Fainting
- ☐ Seizures
- ☐ Numbness or tingling
- ☐ Speech Difficulties
- ☐ Trouble Sleeping
- ☐ Feel tired all the time
- ☐ Feel nervous, tense, or stressed
- ☐ Feel depressed
- ☐ Increased thirst or urination
- ☐ Hot/Cold Intolerance
- ☐ Skin rashes
- ☐ Sneezing or itchy watery eyes

FEMALES ONLY:

- ☐ Discharge from breast
- ☐ Vaginal discharge/bleeding
- ☐ Pain with intercourse

MALES ONLY:

- ☐ Testicular swelling or pain
- ☐ Penile rash or discharge
- ☐ Pain with intercourse

List ALL MEDICATIONS you take (including over-the-counter (OTC) medications, herbal supplements, and vitamins) or ☐ **NONE**

Name of Medication	Dosage	Frequency

PERSONAL MEDICAL HISTORY: *(please select all that apply)* or ☐ **NONE**

- ☐ ADHD
- ☐ Alcoholism
- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bladder Problems
- ☐ Bleeding Problems
- ☐ Cancer: _____
- ☐ Crohn's Disease
- ☐ COPD/Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diverticulitis
- ☐ DVT (Blood Clot)
- ☐ GERD (Acid Reflux)
- ☐ Heart disease
- ☐ Heart Attack
- ☐ Hiatal Hernia
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Lupus
- ☐ Liver Disease
- ☐ Macular Degeneration
- ☐ Irregular Heart Rate
- ☐ Neuropathy
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Peptic Ulcer
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis

Other medical problems not listed above:

_____

_____

Have you ever had any of the following? or ☐ **NONE**

TEST	DATE	TEST	DATE
☐ Abdominal ultrasound	_____	☐ Chlamydia	_____
☐ Abdominal CT/CAT scan	_____	☐ Sexually Transmitted Infections Screenings	_____
☐ Cardiac Stress Test	_____	☐ Hepatitis B testing	_____
☐ Bone Mineral Density Testing	_____	☐ Hepatitis C testing	_____
☐ Dental Exam	_____	☐ Syphilis	_____
☐ Eye Exam	_____	☐ Gonorrhea	_____
☐ CT/CAT scan of lungs	_____	☐ Alcohol Misuse counseling	_____
☐ Blood glucose testing	_____	☐ Depression Screening	_____
☐ TB test	_____	☐ Other: _____	_____
☐ Sleep Study	_____	**IMMUNIZATION**	**DATE OF LAST DOSE**
☐ Prostate Specific Antigen (PSA) testing	_____	☐ Tetanus	_____
☐ Cholesterol/Lipids testing	_____	☐ Flu vaccine	_____
☐ BRCA gene testing	_____	☐ Pneumonia vaccine	_____
☐ Stool blood test	_____	☐ Shingles vaccine	_____
☐ Colonoscopy	_____	☐ HPV vaccine	_____
☐ HIV testing	_____	☐ Other: _____	_____

SURGERIES or ☐ **NONE**

Type of Surgery	Approximate Date	Hospital & Surgeon Name

PREVIOUS HOSPITALIZATIONS: *(include all non-surgical hospitalizations)* or ☐ **NONE**

Reasons for Hospital Stay	Approximate Date	Hospital Name

FEMALES ONLY: **Age when menstrual cycles began: ____ Age when menstrual cycles stopped: ____ ☐ N/A**

First Day of Last Menstrual Cycle: _____ ☐ Normal ☐ Abnormal ☐ N/A

Date of Last Pap Test: _____ ☐ Normal ☐ Abnormal ☐ N/A

Date of Last Pap/HVP cotest: _____ ☐ Normal ☐ Abnormal ☐ N/A

Date of Last Mammogram: _____ ☐ Normal ☐ Abnormal ☐ N/A

No. of Pregnancies: ____ ☐ Term: ____ ☐ Preterm: ____ ☐ Miscarriages: ____ ☐ Abortions: ____ ☐ Living Children: ____

Do you have personal history of hysterectomy? ☐ Yes: ☐ Abdominal approach ☐ Vaginal approach or **☐ No**

If Yes, why? _____

If Yes, was your cervix removed? **☐ Yes ☐ No** *Were your ovaries removed?* **☐ Yes ☐ No**

SOCIAL HISTORY: *(please select all that apply)*

Alcohol Use
☐ Yes ☐ No ☐ Former
Years drinking _____
Drinks per week* _____
Type _____
Quit Date _____
Last Drink _____

Tobacco Use
☐ Yes ☐ No ☐ Former
Type _____
Amount per day _____
Years of Use _____
Year Quit _____
Want to quit? ☐ Yes ☐ No

Recreational Drug Use
☐ Yes ☐ No ☐ Former
Type _____
Years of Use _____
Year Quit _____
Want to quit? ☐ Yes ☐ No
IV Drug Use? ☐ Yes ☐ No

Caffeine
☐ Yes ☐ No ☐ Former
Type _____
Amount per day _____

Exercise
☐ Yes ☐ No
Type _____
Hours per week _____

Diet
Diet Type _____
Any restriction? ☐ Yes ☐ No
If yes, specify: _____

Sexual History
Currently sexually active?
☐ Yes ☐ No

Birth control method(s)?
☐ Yes ☐ No
If Yes, specify: _____
Lifetime sexual partner(s): _____
New partner in past 3 months?
☐ Yes ☐ No
History of sexually transmitted infections?
☐ Yes ☐ No
If Yes, specify: _____

Personal Safety
Do you wear seatbelt?
☐ Yes ☐ No

Do you have difficulty dressing yourself?
☐ Yes ☐ No

Do you have difficulty carrying 10 lbs?
☐ Yes ☐ No

Do you have difficulty shopping?
☐ Yes ☐ No
Have you had a fall in the last year?
☐ Yes ☐ No

Mental Health
Feeling down, depressed, or hopeless?
☐ Yes ☐ No

Do you have difficulty sleeping?
☐ Yes ☐ No

Occupation
Do you work? ☐ Yes ☐ No
☐ Retired
If yes, specify occupation:
_____
☐ Full-time ☐ Part-time

* One Standard Drink is found in 12 oz. of regular beer, 5 oz. of wine, 1.5 oz. of distilled spirits.

FAMILY HISTORY:

FATHER: **Living: Age** _____ **Deceased: Age** _____ **Cause:** _____

☐ Alcoholism	☐ Cancer: _____	☐ Diabetes Type 2	☐ Kidney Disease
☐ Anemia	☐ COPD/Emphysema	☐ DVT (Blood Clot)	☐ Migraines
☐ Asthma	☐ Dementia	☐ Heart Disease	☐ Osteoporosis
☐ Arthritis	☐ Depression	☐ High Cholesterol	☐ Stroke
☐ Bipolar Disorder	☐ Diabetes Type 1	☐ High Blood Pressure	☐ Thyroid Disorder

Other medical problems not listed above: _____

MOTHER: **Living: Age** _____ **Deceased: Age** _____ **Cause:** _____

☐ Alcoholism	☐ Cancer: _____	☐ Diabetes Type 2	☐ Kidney Disease
☐ Anemia	☐ COPD/Emphysema	☐ DVT (Blood Clot)	☐ Migraines
☐ Asthma	☐ Dementia	☐ Heart Disease	☐ Osteoporosis
☐ Arthritis	☐ Depression	☐ High Cholesterol	☐ Stroke
☐ Bipolar Disorder	☐ Diabetes Type 1	☐ High Blood Pressure	☐ Thyroid Disorder

Other medical problems not listed above: _____

SIBLINGS: _____

_____

☐ **Unknown family history/Adopted**

GENERAL QUESTIONS:

Are there any personal problems/concerns at home, work, or school you would like to discuss? ☐ **Yes** ☐ **No**

Are there any cultural or religious concerns you have related to your care? ☐ **Yes** ☐ **No**

Are there any financial issues that directly impact your ability to manage your health? ☐ **Yes** ☐ **No**

Are there any vision problems that affect your communication? ☐ **Yes** ☐ **No**

Are there any hearing problems that affect your communication? ☐ **Yes** ☐ **No**

Are there any limitations to understanding or following instructions? ☐ **Yes** ☐ **No**

Current Living Situation *(check all that apply):* ☐ **House or apartment** ☐ **Shelter** ☐ **Homeless**

☐ **Other:** _____

Who do you live with at home? _____ or ☐ **Live alone**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Other:** _____

How many children do you have and what ages? _____ or ☐ **NONE**

Education Level: ☐ **Elementary** ☐ **High School** ☐ **Vocational** ☐ **College** ☐ **Graduate/Professional**

List other medical providers that you see or receive treatment from on a regular basis.

(Ex: Cardiologist, Mental Health Provider, Kidney Specialist, and Dentist.)

_____

_____

Pharmacy: _____

Are there any other concerns that you would like to discuss during your visit today?

_____

_____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____