Bryn Mawr Medical Specialists Association
Haverford Medical Associates
937 E. Haverford Road, Ste 103
Bryn Mawr, PA 19010

ADULT HEALTH ASSESSMENT

In order to help us deliver quality care, we would appreciate your responses to the personal history questions below. Please be assured that all responses are kept confidential. You should feel free to discuss any questions you have concerning these items with the doctor or nurse.

DO YOU HAVE ANY PARTICULAR HEALTH CONCERNS AT THIS TIME YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR OR NURSE? _____

_____

_____

ALLERGIES

Do you have any allergies to medications, foods, or other substances? If yes, please list along with your reaction.

_____ _____

_____ _____

MEDICATIONS

Please list all **medications** including **dosage** that you currently take (prescription, over the counter, vitamins, herbs, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please check if you have any of these diseases or if you have any of these symptoms that recur frequently:

___ High Blood Pressure
___ Blood Disorders
___ Heart Disease
___ Shortness of Breath
___ Lightheadedness
___ Asthma
___ Persistent Cough
___ Indigestion
___ Constipation
___ Blood in Stool
___ Unexplained Weight Loss
___ Gall Bladder Disease
___ Thyroid Disease
___ Migraine
___ Difficulty Urinating
___ Low Back Problems
___ Anemia
___ Sexually Transmitted Disease
___ Depression
___ Drug Abuse
___ Vision Problems
___ Chicken Pox
___ Sinus Problems
___ Diabetes
___ Chest Pain/Tightness
___ Swollen Ankles
___ Rheumatic Fever
___ Bronchitis
___ Hay Fever
___ Nausea
___ Diarrhea
___ Hemorrhoids
___ Unexplained Weight Gain
___ Pancreatitis
___ Head or Neck Radiation
___ Kidney Disease
___ Frequent Urination
___ Bone/Joint Problems
___ Lumps/Moles
___ HIV/AIDS
___ Sleeping Problems
___ Gout
___ Hearing Problems
___ Mumps
___ Hepatitis/Yellow Jaundice
___ Cancer
___ Heart Murmur
___ Palpitations/Heart Pounding
___ Tuberculosis
___ Pneumonia
___ Abdominal Discomfort
___ Vomiting
___Change in Bowel Habits
___ Ulcers
___ Colitis
___ Liver Disease
___ Headache
___ Kidney Stones
___ Arthritis
___ Blood Transfusions
___ Skin Disease
___ Anxiety
___ Alcohol Abuse
___ Seizures
___ Measles
___ _____

Please list all **hospitalizations** and **operations** you have had and give the approximate date of each:

_____ _____
_____ _____
_____ _____
_____ _____

For **women** only:

_____ Date of last menstrual cycle
_____ Age at onset of periods
___ yes ___ no Do you do self breast exams monthly?
___ yes ___ no History of abnormal pap smears? If yes, explain_____
___ yes ___ no Prolonged or abnormal bleeding?
___ yes ___ no Pelvic Pain?
___ yes ___ no Abnormal discharge?
___ yes ___ no Do you take a calcium supplement?
_____ Number of pregnancies
_____ Number of miscarriages or abortions

For **men** only:

___ yes ___ no Do you do self testicular exams?
___ yes ___ no Have you had a prostate exam?
___ yes ___ no Have you had a PSA (blood work to check your prostate)?
___ yes ___ no Have you ever had an abnormal prostate exam or PSA?
If yes, please explain _____
___ yes ___ no Do you have any problems with urination?
If yes, please explain _____

SEXUAL HISTORY

___ yes ___ no Are you sexually active?
___ yes ___ no Do you have multiple partners?
___ yes ___ no Do you use condoms?
_____ Method of contraception?
_____ Sexual preference (e.g. heterosexual, bisexual, gay, lesbian, etc.)

FAMILY HISTORY

___ yes ___ no Mother alive? If not, age and cause of death _____
___ yes ___ no Father alive? If not, age and cause of death _____
_____ Number of sisters
_____ Number of brothers
___ yes ___ no Any siblings have serious illness?
If yes, please explain _____
_____

Has anyone in your **immediate family** had any of the following diseases?

			Family Member	Age at diagnosis
___ yes	___ no	Cancer (describe type)	_____	_____
___ yes	___ no	High Blood Pressure	_____	_____
___ yes	___ no	Heart Disease	_____	_____
___ yes	___ no	Stroke	_____	_____
___ yes	___ no	Mental Disease	_____	_____
___ yes	___ no	Glaucoma	_____	_____
___ yes	___ no	Drug/Alcohol Addiction	_____	_____
___ yes	___ no	Bleeding Disorders	_____	_____
___ yes	___ no	Diabetes	_____	_____
___ yes	___ no	Asthma	_____	_____
___ yes	___ no	Epilepsy	_____	_____
___ yes	___ no	Genetic Disease	_____	_____
___ yes	___ no	Arthritis	_____	_____
___ yes	___ no	Kidney Problems	_____	_____
___ yes	___ no	Other (describe)	_____	_____

_____

_____

SOCIAL HISTORY

How many people live with you now? _____

Present occupation? _____

Previous occupations? _____

Have you ever worked with chemicals, paints, asbestos or other hazardous materials? _____

_____

Have you ever been exposed to any environmental hazards such as radiation, toxic waste or lead paint? _____

_____

PERSONAL HABITS

___ yes	___ no	___ n/a	Do you wear seatbelts
___ yes	___ no	___ n/a	Do you wear a bike helmet
___ yes	___ no	___ n/a	Do you use tobacco products
			If yes, what _____ how much _____
___ yes	___ no	___ n/a	Do you drink alcohol
			If yes, how much per week _____
___ yes	___ no	___ n/a	Do you drink coffee
			If yes, how many cups per day _____
___ yes	___ no	___ n/a	Do you drink Tea
			If yes, how many cups per day _____
___ yes	___ no	___ n/a	Do you follow a particular diet
			If yes, what type _____
___ yes	___ no	___ n/a	Do you exercise regularly
			If yes, what type _____
___ yes	___ no	___ n/a	Any recent travel outside the U.S.
___ yes	___ no	___ n/a	Do you use drugs (cocaine, crack, marijuana, etc.)
___ yes	___ no	___ n/a	Do you have smoke detectors in your home

IMMUNIZATIONS

___ yes	___ no	Hepatitis B	Approximate date _____
___ yes	___ no	Tetanus	Approximate date _____
___ yes	___ no	Flu vaccine	Approximate date _____
___ yes	___ no	Pneumovax	Approximate date _____
___ yes	___ no	Measles	Approximate date _____
___ yes	___ no	Mumps	Approximate date _____
___ yes	___ no	Rubella	Approximate date _____

HEALTH MAINTENANCE

Please indicate the approximate date these tests were performed for you:

_____	Pap Smear
_____	Breast Exam
_____	Mammogram
_____	Complete Physical Exam
_____	Cholesterol Check
_____	Stool Check for Blood
_____	Prostate Exam
_____	Sigmoid Exam

___ yes	___ no	Do you have a "living will" or advance directive
___ yes	___ no	Are you an organ donor