

ABBOTT NORTHWESTERN MEDICAL ASSOCIATES - SARTELL
2000 Abbott Northwestern Court, Suite 205
Sartell, MN 56377
320-534-2600

New Adult Patient Health History

NAME: _____ DATE: _____

Social security number: _____ DOB: _____

Phone Number: _____ Alternate Phone Number: _____

PAST MEDICAL HISTORY

Please list any chronic or acute disease/diagnosis that you have been found to have.

DIAGNOSIS	DATE

HOSPITALIZATIONS

REASON	WHERE	DATE

SURGERIES

REASON	WHERE	DATE

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FAMILY HISTORY

Family Member	Age (or age at death)	Medical Problems
Father	_____ ()	_____
Mother	_____ ()	_____
Siblings	_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____
	_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____
	_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____
	_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____
	_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____
Children	_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____
	_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____
	_____ <input type="checkbox"/> M <input type="checkbox"/> F	_____

Adverse reaction to anesthetics _____

SOCIAL HISTORY

What is/was your occupation _____ Significant Other _____

What is the highest level of education you have completed?

Grade School High School College Post Graduate

Do you have any special cultural or religious needs? (Optional)

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Personal Habits

Caffeine _____ How many cups per day? _____

Tobacco History: Please Circle One.

Never

Quit, if so, how many years did you use tobacco and how much did you use per day? _____

Currently, How much per day and for how many years? _____

Alcohol _____ How much per day/week? _____

Have you ever been in the military? _____

Have you ever received a blood transfusion? _____

Please list any occupations or hobbies that are hazardous to your health. _____

Average hours of sleep per day? _____

Do you modify your diet for: salt cholesterol saturated fat sugar calories

Are you on a diabetic diet? Yes or NO

Do you exercise regularly? Yes No

If yes, what kind of exercise, how often and amount of time: _____

Do you wear a bike helmet while riding a pedal bike or motorcycle? Yes No N/A

Do you wear a seat belt when in a vehicle? _____

Females Only: Do you do monthly breast exams? Yes or No

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EDUCATIONAL CONCERNS

Are there any barriers that prevent you from being able to learn?

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Cultural |
| <input type="checkbox"/> Language | <input type="checkbox"/> Spiritual/Religious |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Emotional State |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Problems with Thinking
or Understanding |
| <input type="checkbox"/> Physical | |
| <input type="checkbox"/> Other | |

Your primary language spoken/read is English? Yes No

If no, what is your primary language? _____

What is the best way for you to learn?

- | | |
|--|--|
| <input type="checkbox"/> Verbal | <input type="checkbox"/> Audio/visual |
| <input type="checkbox"/> Written | <input type="checkbox"/> Demonstration |
| <input type="checkbox"/> Caretaker needs to receive education? | |
| Who? _____ | |
| Other: _____ | |

Do you have an advanced directive or living will? Yes NO

If so we would like a copy to put in your chart.

Do you want further information on advanced directives or living wills? Yes NO

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REVIEW OF SYSTEMS

Please circle the symptom or disease if present.

GENERAL

Fevers
 Fatigue
 Weakness

EARS/NOSE/THROAT

Headaches
 Ringing in ears
 Hoarseness
 Difficulty swallowing
 Decreased hearing
 Sinus problems

EYES

Blurry vision
 Double vision
 Cataracts/Glaucoma

CARDIOVASCULAR

Chest pain/pressure
 Palpitations
 Rheumatic fever
 Heart murmur
 High cholesterol
 Hypertension
 Swelling in feet

RESPIRATORY

Recurrent infections
 COPD
 Asthma
 Chronic cough
 Tuberculosis
 Sleep apnea

GASTROINTESTINAL

Food intolerances
 Indigestion/heartburn
 Hiatal hernia
 Ulcers
 Blood in stool

MUSCULSKETAL

Arthritis
 Gout
 Leg cramps
 Back/neck pain

SKIN

Rashes
 Itching
 Psoriasis

GENITO-URINARY

Kidney infections
 Kidney stones
 Bladder infections
 Urinary frequency
 Incontinence

FEMALES ONLY

Breast lumps
 Currently pregnant
 Current on PAPs
 Mammograms current

MALES ONLY

Prostate problems
 Testicular swelling
 Erectile Dysfunction

PSYCHOLOGICAL

Anxiety
 Depression
 Panic attacks
 Hallucinations

ENDOCRINE

Heat/Cold intolerance
 Weight changes
 Thyroid problems

HEMATOLOGICAL

Anemia
 Abnormal bruising

NEUROLOGICAL

Seizures
 Strokes/TIAs
 Memory changes
 Word finding difficulty

RELATIONSHIPS

Are you currently or have you been in a relationship where you were physically abused?
Yes No Yes, In the Past

Are you currently or have you been in a relationship where you have been emotionally abused?
Yes No Yes, In the Past

Any other questions or concerns you would like to address with your provider?

Please bring the following with you to your appointment:

- 1. Medication bottles.**
- 2. Previous medical reports, if any.**
- 3. Recent blood test result, if any**

The form was reviewed and entered into the EMR on

Date: _____ By: _____ .