University of Rochester
UNIVERSITY HEALTH SERVICE
Preventive Care History
Established Patient

Date:

Name:
Birthdate: Age:
Phone #: (H) (W)
Phone # (cell)

Do you have a chosen/preferred name?
Pronouns:

PRESENT HEALTH CONCERNS

MEDICATIONS: (Include prescription and over-the-counter medicines, vitamins, home remedies, birth control pills, herbs, etc.)

Medication	Dose/How Often	Reason	Medication	Dose/How Often	Reason
☐ **no new**					

ALLERGIES OR REACTIONS

Any new allergies?

PERSONAL MEDICAL HISTORY

Any new medical problems, illnesses, surgeries, or hospitalizations since your last physical?

IMMUNIZATIONS/VACCINATIONS (Indicate date of most recent.)

Hepatitis A
Measles
Tetanus (Td)
Tetanus/Pertussis (Tdap)
Hepatitis B Series
HPV (under age 26)
Shingrix
PPD (Screen for tuberculosis)
Influenza (flu shot)
MMR (measles / mumps / rubella)
Varicella (chicken pox) shot or illness
Pneumococcal Vaccine
Other

HEALTH MAINTENANCE (Screening tests – Indicate date & result of most recent.)

Lipid Profile (Cholesterol) Result?
PSA (Prostate cancer screen) Result?
Colonoscopy Result?
Result?
Stool test for blood Result?
Mammogram Result?
Ever abnormal? ☐ Yes ☐ No
Details:

OTHER HEALTH CARE PROVIDERS (Please list names of any other health care providers.)

	Name of Provider	Date of last visit
Dentist:		
Eye:		
GYN:		
Other:		

FAMILY MEDICAL HISTORY

Any new family history of illness since your last physical? _____

Social History

Occupation: _____ Employer: _____
Years of education/highest degree:

Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner Spouse/Partner's name: _____ # of children/ages: _____ Who lives at home with you? _____
Tobacco Use:	Cigarettes: ☐ Never ☐ Current Smoker - # of packs a day: _____ # of years: _____ Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape Are you interested in quitting? ☐ Yes ☐ No
Alcohol Use:	Do you drink alcohol? ☐ Yes ☐ No # of drinks/week: _____ Is alcohol use a concern for you or others? ☐ Yes ☐ No
Drug Use:	Do you currently (within past 1-2 years) use any recreational drugs? ☐ Yes ☐ No Have you ever used needles for recreational drug usage? ☐ Yes ☐ No Do you have or have you ever had abuse/addiction to drugs or alcohol? ☐ Yes ☐ No
Caffeine Intake:	☐ None ☐ Sodas - #of cups/day: _____ ☐ Coffee/tea - # of cups per day: _____ ☐ Chocolate – oz./day: _____
Eating Habits:	Are you satisfied with your weight? ☐ Yes ☐ No How do you describe your eating habits? ☐ Good ☐ Fair ☐ Poor ☐ Low fat ☐ Special Do you eat at least 5 servings of fruits and/or vegetables a day? ☐ Yes ☐ No Do you consume at least 3 servings of dairy daily or take calcium/vitamin D supplement? ☐Yes ☐No Do you take supplements/vitamins/herbs? (please list) _____
Physical Activity:	On average, how many days per week do you engage in moderate to vigorous physical activity, such as brisk walking? _____ On average, how many minutes do you engage in physical activity at this level? _____ How many days a week do you perform muscle strengthening exercises, such as bodyweight exercises or resistance training?
Other:	Do you use a helmet when you ride a bike, roller blade, ski or participate in other sport where use of helmet recommended? ☐ Yes ☐ No Do you have a gun in your home? ☐ Yes ☐ No Is it stored safely? ☐ Yes ☐ No Do you use seatbelts consistently, even when a passenger? ☐ Yes ☐ No Do you have a smoke detector in your home? ☐ Yes ☐ No Carbon monoxide meter? ☐ Yes ☐ No Do you have difficulty sleeping? Is VIOLENCE at home or at the workplace a concern for you? ☐ Yes ☐ No vs. do you feel safe at home/ at your job? Have you ever been ABUSED? ☐ Yes ☐ No Do you ever feel unsafe in your present relationship? ☐ Yes ☐ No

REVIEW OF SYSTEMS

(Check all current problems you are having.)

General
- ☐ Change in weight
- ☐ Fatigue
- ☐ Fever or chills

Skin
- ☐ Acne
- ☐ Change in mole or other skin lesions

Head, Eyes, Ears, Nose, Throat
- ☐ Frequent nosebleeds
- ☐ Hay fever
- ☐ Hearing loss/Difficulty hearing
- ☐ Hoarseness
- ☐ Sinus problems
- ☐ Swollen glands
- ☐ Vision problems, eye pain, loss of vision

Lungs
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Cardiac/Heart
- ☐ Chest Pain
- ☐ Palpitations/skipped heart beats
- ☐ Swollen ankles

Gastrointestinal Issues
- ☐ Bloody or black stools
- ☐ Change in appetite
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Frequent stomach pain
- ☐ Heartburn
- ☐ Persistent diarrhea
- ☐ Recent change in bowel habits

Urinary
- ☐ Bladder or kidney infections
- ☐ Leaking of urine
- ☐ Trouble passing urine
- ☐ Waking up at night to urinate

Musculoskeletal
- ☐ Back pain
- ☐ Joint problems
- ☐ Tendonitis

Mental Health
- ☐ Abuse
- ☐ Addictions
- ☐ Anxiety or nervousness
- ☐ Mood changes/depression

Neurology
- ☐ Dizziness, fainting
- ☐ Frequent or severe headaches
- ☐ Numbness or tingling sensations

Other:_____

_____

_____

SEXUAL HEALTH

For Every Person		**Comments**
What is your sexual orientation? ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Straight ☐ Pansexual ☐ Asexual ☐ My orientation is not listed here (check all that apply) _____		
Have you have had sex of any kind? If yes, are you interested in being screened for sexually transmitted infections today?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Receptive ☐ Penetrative ☐ Receptive ☐ Penetrative
Do you have (check all that apply): • Oral-genital (mouth on penis/vagina)? • Vaginal sex (penis, hands, fingers, sex toy in vagina)? • Anal sex (penis, hands, fingers, sex top in anus)? • Oral-anal (mouth on anus)? Other _____	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

For Persons with a Penis

1. Do you have testicular pain or swelling?	☐ Yes ☐ No	
2. Do you have discharge from your penis?	☐ Yes ☐ No	
3. Do you examine your testes?	☐ Yes ☐ No	

For Persons with Vaginas

1. Do you need a pelvic exam at this appointment?	☐ Yes ☐ No	
2. Have you reached menopause?	☐ Yes ☐ No	Age:
3. Are your periods regular?	☐ Yes ☐ No	
4. How many times have you been pregnant? _____		
5. How many live births? _____ Miscarriages? _____ Terminations? _____		
6. When was your last PAP smear? _____		
7. Have you noticed any of the following: changed in menstrual periods, vaginal itching or discharge, or vaginal bleeding after menopause?	☐ Yes ☐ No	
8. Have you ever experienced pain or bleeding with intercourse?	☐ Yes ☐ No	

For Persons with Breast

1. Do you examine your breasts?	☐ Yes ☐ No	
2. Have you ever noticed a breast lump or discharge?	☐ Yes ☐ No	

Reviewed MD/DO/PA/NP
Signature: _____ **Date:** _____