Name: _____ DOB: _____ Date: _____

Dr Stefana Pecher, LLC
Country Doc Walk-In & Wellness LLC
391 Norwich Westerly Road PO Box 417
North Stonington, CT 06359

Tel: (860) 535-4600
Tel: (860) 245-4466

Fax: (860) 535-4605
Fax: (860) 245-4468

ADULT HEALTH ASSESSMENT FORM

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 medical assistant.

DO YOU HAVE ANY PARTICULAR HEALTH CONCERNS AT THIS TIME YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR OR NURSE? YES OR NO If yes, please explain: _____

_____

_____

ALLERGIES

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, FOODS OR OTHER SUBSTANCES? IF YES, PLEASE LIST. _____

_____

_____

MEDICATIONS

PLEASE LIST ALL **MEDICATIONS** INCLUDING THE **DOSES** THAT YOU ARE CURRENTLY TAKING: (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 REOCCUR FREQUENTLY:

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

Name: _____ DOB: _____ Date: _____

PLEASE COMPLETE ALL PAGES

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 of Onset of periods: _____

Do you do self breast exams monthly? No ☐ Yes ☐

Any history of abnormal Pap Smears? No ☐ Yes ☐

Any prolonged or abnormal bleeding? No ☐ Yes ☐

Any pelvic pain? No ☐ Yes ☐

Any abnormal discharge? No ☐ Yes ☐

Do you take a calcium supplement? No ☐ Yes ☐

Number of pregnancies: _____ Number of miscarriages or abortions: _____

FOR **MEN** ONLY:

Do you do self testicular exams? No ☐ Yes ☐

Have you had a prostate exam? No ☐ Yes ☐

Have you had a PSA (blood work to check your prostate?) No ☐ Yes ☐

Have you ever had an abnormal prostate exam or PSA? No ☐ Yes ☐ If yes, please explain:

_____

Do you have any problems with urination? No ☐ Yes ☐ If yes, please explain:

_____

SEXUAL HISTORY

Are you sexually active? No ☐ Yes ☐

Do you have multiple sexual partners? No ☐ Yes ☐

Would you characterize your sexual preferences as: Heterosexual ☐ Homosexual ☐ Bisexual ☐

Do you use condoms? No ☐ Yes ☐

What method of contraception do you use? _____

FAMILY HISTORY

Is your mother alive? No ☐ Yes ☐ If not, age at death and cause: _____

Is your father alive? No ☐ Yes ☐ If not, age at death and cause: _____

Number of siblings: Sisters: _____ Brothers: _____

Do any of your siblings have a serious illness? No ☐ Yes ☐

HAS ANYONE IN YOUR **IMMEDIATE** FAMILY HAD ANY OF THE FOLLOWING ILLNESSES?

Illness	Family Member	Age when diagnosed	Illness	Family Member	Age when diagnosed
Cancer (describe type)			Bleeding Disorders		
High Blood Pressure			Diabetes		
Heart Disease			Asthma		
Strokes			Epilepsy		
Mental Disease			Genetic Disease		
Glaucoma			Arthritis		
Drug/Alcohol Addiction			Kidney Problems		
			Other		

Name: _____ DOB: _____ Date: _____

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? IF SO, PLEASE EXPLAIN: _____

HAVE YOU EVER BEEN EXPOSED TO ANY ENVIRONMENTAL HAZARDS SUCH AS RADIATION, TOXIC WASTE, OR LEAD PAINT? IF SO, PLEASE EXPLAIN: _____

PERSONAL HABITS

Do you wear a seat belt?	No ☐ Yes ☐
Do you wear a bike helmet?	No ☐ Yes ☐ N/A ☐
Do you use tobacco products?	No ☐ Yes ☐ If yes, what kind? _____ How much? _____
Do you drink alcohol?	No ☐ Yes ☐ If yes, how much per week? _____
coffee?	No ☐ Yes ☐ If yes, how many cups per day? _____
tea?	No ☐ Yes ☐ If yes, how many cups per day? _____
Do you follow a particular diet?	No ☐ Yes ☐ If yes, what type? _____
Do you exercise regularly?	No ☐ Yes ☐ If yes, what type? _____
Any recent travel outside the U.S.?	No ☐ Yes ☐
Do you have a gun in the house?	No ☐ Yes ☐ If yes, is it under lock and key? _____
Do you use drugs? (cocaine, crack, marijuana, amphetamines, etc)	No ☐ Yes ☐
Do you have smoke detectors in your home?	No ☐ Yes ☐

IMMUNIZATIONS

Hepatitis B?	No ☐	Yes ☐	Approximate Date:
Tetanus?	No ☐	Yes ☐	Approximate Date:
Flu Shot?	No ☐	Yes ☐	Approximate Date:
Pneumovax?	No ☐	Yes ☐	Approximate Date:
Measles?	No ☐	Yes ☐	Approximate Date:
Mumps?	No ☐	Yes ☐	Approximate Date:
Rubella?	No ☐	Yes ☐	Approximate Date:

HEALTH MAINTENANCE

WHEN WAS YOUR **LAST**: (give approximate date)

Pap Smear? _____
Breast Exam? _____
Mammogram? _____
Complete Physical? _____

Cholesterol Check? _____
Stool check for blood? _____
Prostate Exam? _____
Sigmoid Exam? _____

DO HAVE A "**LIVING WILL**" OR **ADVANCE DIRECTIVE**? No ☐ Yes ☐
ARE YOU AN ORGAN DONOR? No ☐ Yes ☐

COMPLETED BY: _____ DATE: _____

REVIEWED BY: _____ DATE: _____

Revised 2/2015