Ivinson MEMORIAL HOSPITAL
MEDICAL GROUP

Adult Patient Paperwork

Patient Information

Name: _____
LAST FIRST M.I.

Preferred Name:_____ Date of Birth: _____/_____/_____ Age: _____

Phone: (_____) _____ Preferred Contact Method:
email phone text mail

Employer:_____ Occupation: _____

Current Medications

MEDICATION	DOSE	HOW OFTEN

Local Pharmacy:_____ Mail Order Pharmacy:_____

Allergies

MEDICATION	REACTION

Do you have any other allergies (latex, iodine, food or environment)?

_____

_____

Ivinson MEMORIAL HOSPITAL
MEDICAL GROUP

Medical History

Do you have any health problems? (check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder or Kidney Problems
- ☐ Blood Clots or Stroke
- ☐ History of Blood Transfusion
- ☐ Depression
- ☐ Diabetes
- ☐ Stomach or Bowel Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hospitalizations other than childbirth
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Mental Health Concerns
- ☐ Migraine Headaches
- ☐ Neurologic Problems
- ☐ Seasonal Allergies
- ☐ Serious Injuries / Accidents
- ☐ Sleep Apnea
- ☐ Thyroid Problems
- ☐ Stomach Ulcers
- ☐ Other:_____
- ☐ Other:_____

Please explain and checked boxes

_____

_____

_____

Surgical History	
Surgical Area/Procedure	Year Completed and other details
Appendectomy	
Bone/Joint surgery	
EGD	
Colonoscopy	
Gallbladder surgery	
Hernia repair	
Hysterectomy	
Cancer (specify where)	
Ear/Nose/Throat	
Tubal Ligation	
Vasectomy	
Other:	

Ivinson MEMORIAL HOSPITAL
MEDICAL GROUP

Family History

Is your father alive? Yes *No Age_____
*If deceased, at what age and reason for death: _____

Did he have any other medical problems? _____

Is your mother alive? Yes *No Age_____

*If deceased, at what age and reason for death:_____

Did she have any other medical problems? _____

Do any of your immediate family members have any of the following, please include: siblings, parents, grandparents.

Medical Condition	Yes	No	Who (immediate family members)
Cancer (type)			
Blood Clot/Stroke			
Diabetes			
Heart Disease			
High Blood Pressure			
Thyroid Problems			
Other			

Social History

Marital Status: Single Married Divorced Separated Widowed

Do you smoke cigarettes or e-cigarettes? No *Yes
*How much? _____ *How many years? _____ *Former Smoker, when did you quit? _____

Do you use chewing tobacco, snuff, or other forms of tobacco? No *Yes
*Please list what type:_____

Do you use recreational drugs (marijuana, etc.)? No *Yes
*Please list what type:_____

Do you drink alcohol? No *Yes
*How many glasses of wine/liquor, mixed drinks/beer per week? _____

Ivinson Memorial Hospital
MEDICAL GROUP

Immunization History	
DATE RECEIVED	IMMUNIZATION
	Tdap (Tetanus, diphtheria and pertussis-whooping cough)
	Tetanus
	Pneumonia Vaccine (PCV 23)
	Prevnar (PVC 13)
	Zostavax (Shingles)
	Influeza (flu)
	Hepatitis (A/B)
	Meningococcal (Meningitis)

Health Maintenance	
DATE RECEIVED	IMMUNIZATION
	Bone Density (DEXA Scan)
	Mammogram
	Pap Smear
	Prostate Screen
	PSA

System Review

Please check all that currently apply:

- ☐ Poor Appetite
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fever
- ☐ Chills
- ☐ Excess Sweating
- ☐ Fatigue
- ☐ Temperature Intolerance
- ☐ Ear Pain
- ☐ Ear Drainage
- ☐ Ear Blockage
- ☐ Ringing in Ears
- ☐ Hearing Loss
- ☐ Dizziness
- ☐ Fainting
- ☐ Seasonal Allergies
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Rash on Skin
- ☐ Hair/Nail Problems
- ☐ Itching
- ☐ Headaches
- ☐ Increased Thirst
- ☐ Increased Urine Volume
- ☐ Bloody Sputum
- ☐ Wheezing
- ☐ Chest Pains
- ☐ Heart Palpitations/Skipping
- ☐ Nervousness
- ☐ Depression
- ☐ Trouble Sleeping
- ☐ Voice Change
- ☐ Dental/Gum Issues
- ☐ Throat Discomfort
- ☐ Heartburn/Indigestion
- ☐ Difficulty Swallowing
- ☐ Special Food Tolerance
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Nasal Congestion
- ☐ Nasal Drainage
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Lumps and/or Nodules
- ☐ Snoring
- ☐ Nosebleeds
- ☐ Swollen Glands
- ☐ Bruise or Bleed Easily
- ☐ Muscle/Joint Pain
- ☐ Numbness/Weakness
- ☐ Faulty Memory
- ☐ Eye Pain/Redness
- ☐ Visual Disturbances