FAITH REGIONAL Physician Services, L.L.C.
Endocrinology

301 N. 27th St., Ste. 20, Norfolk, NE 68701
Phone: (402) 844-8680 | Fax: (402) 844-8681
frpsclinics.org |

ADULT MEDICAL INFORMATION FORM

Patient Name: _____ DOB: _____

Physician Being Seen: _____ Date of Appointment: _____

Reason for Visit: _____

Primary Care Provider (PCP): _____

PCP Clinic/Location: _____

Referring Physician: _____

Preferred Pharmacy (Name & City): _____

Medication Allergies: _____

_____

Food Allergies: _____

SOCIAL HISTORY

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: _____

Children: ☐ Yes ☐ No Number of Sons: _____ Number of Daughters: _____

Do you use tobacco? ☐ Yes ☐ No ☐ Formerly Type of tobacco used: _____

Packs Per Day: _____ Years Smoked: _____ Year Quit: _____

Do you vape or use smokeless tobacco? ☐ Yes, currently ☐ Have, but quit ☐ Never

Do you drink alcohol? ☐ Yes ☐ No ☐ Formerly Type: _____

How many drinks per week? _____

Do you have history of elicit/street drug use? ☐ Yes ☐ No Type: _____

Do you have a history of prescription drug abuse? ☐ Yes ☐ No Type: _____

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ADULT MEDICAL INFORMATION FORM

Patient Name: _____ DOB: _____

PAST SURGICAL HISTORY (PLEASE INDICATE YEAR)

- ☐ Angioplasty
- ☐ Angioplasty w/ Stent
- ☐ Appendectomy
- ☐ Arthroscopy Knee
- ☐ Back Surgery
- ☐ Coronary Artery Bypass Graft
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Gallbladder Removal
- ☐ Colectomy
- ☐ Colostomy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ LASIK
- ☐ Liver Biopsy
- ☐ Open Reduction Internal Fixation
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Parathyroidectomy
- ☐ Tonsillectomy

FEMALE SURGICAL HISTORY

- ☐ Augmentation Mammoplasty
- ☐ Bilateral Tubal Ligation
- ☐ Breast Biopsy
- ☐ Cesarean Section
- ☐ D&C
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Reduction Mammoplasty
- ☐ Total Hysterectomy
- ☐ Bilateral Salpingo-Oophrectomy
- ☐ Vaginal Hysterectomy

MALE SURGICAL HISTORY

- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Vasectomy

OTHER SURGERIES NOT LISTED: _____

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ADULT MEDICAL INFORMATION FORM

Patient Name: _____ DOB: _____

MEDICAL HISTORY

- ☐ Alcohol Dependence
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeds Easily
- ☐ Known Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer
- ☐ Chronic Blood Thinner Use
- ☐ Chronic Bronchitis
- ☐ Chronic Fatigue Syndrome
- ☐ Chronic Hepatitis
- ☐ Chronic Kidney Disease
- ☐ Chronic Neck Pain
- ☐ Chronic Sinusitis
- ☐ Circulatory Disease
- ☐ Colitis
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Diarrhea
- ☐ Disc Degeneration
- ☐ Emphysema
- ☐ Esophageal Reflux
- ☐ Gallbladder Stones
- ☐ Gestational Diabetes
- ☐ Goiter
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irregular Heartbeat
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Peripheral Vascular Disease
- ☐ Radiation Treatment
- ☐ Rheumatoid Arthritis
- ☐ Tinnitus
- ☐ Sciatica
- ☐ Seizures/Epilepsy
- ☐ Sleep Apnea
- ☐ Stomach Ulcers
- ☐ Stroke (CVA)
- ☐ Thyroid Disease
- ☐ Unexplained Weight Loss

OTHER SURGERIES NOT LISTED: _____

_____

_____

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ADULT MEDICAL INFORMATION FORM

Patient Name: _____ DOB: _____

FAMILY HISTORY

Please check if any family member has had any of the following conditions and the age of onset.
Also check if it was the cause of death.

☐ Adopted ☐ No Relevant Family History

	Mother	Father	Sister	Brother	Grandparent	Children	Other	Cause of Death
ADD/ADHD								
Alcoholism								
Allergies								
Alzheimer's Disease								
Asthma								
Bleeding Disorders								
Blood Clots								
Blood Disease								
Cancer/Type:								
Coronary Artery Disease								
Coronary Artery Disease (before age 50)								
Depression								
Developmental Delay								
Diabetes								
Eczema								
Hearing Deficiency								
High Cholesterol								
Hypertension								
Inflammatory Bowel Disease								
Kidney Disease								
Learning Disability								
Mental Illness								
Migraines								
Obesity								
Osteoporosis								
Osteoarthritis								
Peripheral Vascular Disease								
Seizures/Epilepsy								
Rheumatoid Arthritis								
Stroke (CVA)								
Thyroid Disease								

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ADULT MEDICAL INFORMATION FORM

Patient Name: _____ DOB: _____

MEDICATIONS

List all your prescribed medications, dosage, and when you started taking the medication.

☐ No Medications ☐ See medication sheet attached

Medication	Dose	Frequency	Year Started

List all the **over the counter medications (supplements, vitamins, etc.)** and the dosage.

☐ No over the counter medications ☐ See medication sheet attached

Medication	Dose	Frequency

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MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____

HEALTHCARE DIRECTIVES

1. Do you have a living will? ☐ Yes ☐ No

2. Do you have a Durable Power of Attorney for Healthcare? ☐ Yes ☐ No

ADMISSION SCREENINGS

1. Have you experienced unintended weight loss (more than 10 pounds) in the last 2 months? ☐ Yes ☐ No

2. Have you ever had the pneumococcal vaccination? ☐ Yes ☐ No

3. Have you had the influenza vaccine this season? ☐ Yes ☐ No

4. Have you had any recent decline in your mobility? ☐ Yes ☐ No

5. Have you had any recent changes in your ability to perform your activities of daily living (dressing, toileting, hygiene, bathing)? ☐ Yes ☐ No

6. Do you have a history of falls? ☐ Yes ☐ No

7. Do you use any assistive devices? ☐ Yes ☐ No

   If yes, please list: _____

8. Are you deaf or do you have difficulty hearing? ☐ Yes ☐ No

9. Are you blind or have difficulty seeing (even when wearing glasses)? ☐ Yes ☐ No

10. Do you have difficulty concentrating or remembering? ☐ Yes ☐ No

11. Do you have difficulty walking or climbing stairs? ☐ Yes ☐ No

12. Do you have difficulty dressing or bathing? ☐ Yes ☐ No

13. Do you have difficulty running errands alone? ☐ Yes ☐ No

DEPRESSION QUESTIONS

1. Do you have little interest or pleasure in doing things?
   ☐ Not at all ☐ Several days ☐ More than half days ☐ Nearly everyday

2. Do you feel down, depressed, or hopeless?
   ☐ Not at all ☐ Several days ☐ More than half days ☐ Nearly everyday

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MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____

HOME CARE

1. Current type of residence

- ☐ Home alone
- ☐ Home with family
- ☐ Homeless
- ☐ Foster home
- ☐ Group home
- ☐ Assisted Living
- ☐ Nursing home
- ☐ Skilled nursing facility
- ☐ Other: _____

2. Support Systems

- ☐ Spouse/significant other
- ☐ Parent
- ☐ Children
- ☐ Family members
- ☐ Case manager/social worker
- ☐ Church
- ☐ Friends/neighbors
- ☐ Homecare staff
- ☐ Organized support groups
- ☐ Shelter
- ☐ Therapist
- ☐ None
- ☐ Other: _____

3. Current assistance at home

- ☐ None
- ☐ Supervised settings
- ☐ Home health
- ☐ Rehabilitation
- ☐ Educational support
- ☐ Equipment
- ☐ Activities of daily living (bathing, dressing, toileting, hygiene, etc.)
- ☐ Medications
- ☐ Respiratory care
- ☐ In-home caregiver

4. Do you currently utilize home care services? ☐ Yes ☐ No

HEALTH LITERACY

1. How often do you have someone help you read health or medical material?
☐ Never ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always

2. How often do you have problems learning about your medical condition because of difficulty understanding written information?
☐ Never ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always

3. How often do you have a problem understanding what is told to you about your health or medical condition?
☐ Never ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always

4. How confident are you filling out health or medical forms by yourself?
☐ Extremely ☐ Quite a bit ☐ Somewhat ☐ A little bit ☐ Not at all

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MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____

EDUCATION

1. What learning and/or communication barriers do you have?

☐ No barriers ☐ Hearing ☐ Financial
☐ Reading ☐ Physical ☐ Other: _____
☐ Language ☐ Emotional _____
☐ Visual ☐ Cognitive

2. What is your preferred language for educational material? _____

3. Would you like an interpreter for education and learning? ☐ Yes ☐ No

4. Are you ready to learn about your health plan and plan of care? ☐ Yes ☐ No

5. Do you have any cultural or religious beliefs that might impact your education and learning?

☐ Yes ☐ No
☐ If Yes, _____

6. What is the best way for you to learn?

☐ Listening ☐ Demonstration ☐ Other: _____
☐ Reading ☐ Video/Pictures _____

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REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____

PLEASE MARK WHETHER OR NOT YOU ARE EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS.

CONSTITUTION
☐ All Negative
- ☐ Appetite Loss
- ☐ Fever
- ☐ Chills
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Malaise/Fatigue
- ☐ Diaphoresis (Excessive Sweating)
- ☐ Night Sweats

SKIN ☐ All Negative
- ☐ Changes in Nail Beds
- ☐ Discoloration
- ☐ Dryness
- ☐ Flushing
- ☐ Rash
- ☐ Poor Wound Healing
- ☐ Itching
- ☐ Skin Cancer
- ☐ Suspicious Lesions
- ☐ Unusual Hair Distribution

HEAD, EARS, NOSE, THROAT
☐ All Negative
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Tinnitus (Ringing in Ears)
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Stridor (High Pitched Breath Sounds)
- ☐ Sore Throat
- ☐ Dizziness

EYES ☐ All Negative
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Photophobia (Light Sensitivity)
- ☐ Eye Pain
- ☐ Eye Discharge
- ☐ Eye Redness
- ☐ Vision Loss-Left
- ☐ Vision Loss-Right
- ☐ Visual Disturbance
- ☐ Visual Halos

CARDIOVASCULAR
☐ All Negative
- ☐ Chest Pain
- ☐ Cyanosis (Blue Discoloration)
- ☐ Dyspnea on Exertion (Shortness of Breath with Activity)
- ☐ Irregular Heartbeats
- ☐ Palpitations
- ☐ Orthopnea (Shortness of Breath While Lying Flat)
- ☐ Claudication (Inadequate Blood Flow)
- ☐ Near-Syncope (Almost Fainting)
- ☐ Syncope (Fainting)
- ☐ Leg Swelling
- ☐ PND (Shortness of Breath While Sleeping)

PSYCHIATRIC ☐ All Negative
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia

RESPIRATORY ☐ All Negative
- ☐ Cough
- ☐ Hemoptysis (Coughing Up Blood)
- ☐ Sputum Production
- ☐ Shortness of Breath
- ☐ Sleep Disturbances

GASTROINTESTINAL
☐ All Negative
- ☐ Abdominal Bloating
- ☐ Heartburn
- ☐ Anorexia
- ☐ Bowel Habit Changes
- ☐ Bowel Incontinence
- ☐ Nausea
- ☐ Vomiting
- ☐ Hematemesis (Vomiting Blood)
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hematochezia (Rectal Bleeding)
- ☐ Hemorrhoids
- ☐ Jaundice (Yellow Discoloration)
- ☐ Dysphagia (Difficulty Swallowing)
- ☐ Excessive Appetite
- ☐ Flatus (Gas)
- ☐ Blood in Stool
- ☐ Melena (Dark Stools)

MORE QUESTIONS ON BACK SIDE >>

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REVIEW OF SYSTEMS

HEMATOLOGIC
☐ All Negative
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Lymphadenopathy (Swollen Lymph Nodes)

ENDOCRINE
☐ All Negative
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Hair Loss
- ☐ Brittle Nails
- ☐ Brittle Hair
- ☐ Hirsutism (Unwanted Hair Growth)
- ☐ Breast Discharge
- ☐ Breast Lump

GENITOURINARY
☐ All Negative
- ☐ Bladder Incontinence
- ☐ Decreased Libido
- ☐ Dysuria (Painful Urination)
- ☐ Genital Sore
- ☐ Urinary Urgency
- ☐ Urinary Hesitancy
- ☐ Incomplete Emptying
- ☐ Urinary Frequency
- ☐ Nocturia (Excessive Nighttime Urination)
- ☐ Hematuria (Bloody Urine)
- ☐ Flank Pain
- ☐ Menorrhagia (Heavy Menstrual Bleeding)
- ☐ Missed Menses (Missed Period)
- ☐ Non-Menstrual Bleeding
- ☐ Pelvic Pain
- ☐ Polyuria (Excessive Urination)
- ☐ Urinary Retention

MUSCULOSKELETAL
☐ All Negative
- ☐ Arthritis
- ☐ Myalgias (Pain in Muscles)
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Stiffness
- ☐ Falls
- ☐ Gout