

INDIANA ADULT & PEDIATRIC MEDICINE

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Hendricks
Regional Health
MEDICAL GROUP

Dear _____,

Thank you for choosing Indiana Adult and Pediatric Medicine for your health care needs.

In order to make the most of your first visit please fill out the enclosed Health History form as completely as possible and bring it with you to your appointment. It should take 10-15 minutes to complete the form but it will be very helpful getting to know you and planning your care.

The doctor will need a complete list of the medications, either perscription or over-the-counter, that you take on a daily basis or ocasional basis. Also, please be sure to bring your current insurance card. If we participate in your insurance plan, we will be happy to file your claim as long as we have the information to do so. Your co-pay is expected at the time of service.

The time of your visit is listed below We look forward to meeting you!

Sincerely,

The Physicians and Staff of
Indiana Adult & Pediatric Medicine

Appointment for: _____

On: _____

At: _____

Plainfield office

Brownsburg office

If you are unable to keep this appointment, kindly give 24 hours notice.

INDIANA ADULT & PEDIATRIC MEDICINE

Adult Female Health History

Name: _____ Date: _____

Date of Birth: _____ Sex: **Female**

Marital Status: _____ Referred by: _____

Medications (include over-the-counter drugs):

Drug <i>Example: Cardizem CD</i>	Dose <i>1 tab (240mg)</i>	How Often Do You Take It <i>Once a Day</i>
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____
4.) _____	_____	_____
5.) _____	_____	_____
6.) _____	_____	_____

Please attach a separate sheet if needed

Allergies:

	Food or Drug	Your Reaction
1.)	_____	_____
2.)	_____	_____
3.)	_____	_____

Doctors seen in the past 3-6 months: _____

Herbalists, Chiropractors or Other providers seen in the past 3-6 months: _____

Surgeries:

	Type of operation	Date	Doctor or Hospital
1.)	_____	_____	_____
2.)	_____	_____	_____
3.)	_____	_____	_____
4.)	_____	_____	_____

Injuries or Accidents:

Medical History:

• **Hospitalizations:**

Reason for stay

Date

Doctor / Hospital

• **Psychiatric hospitalizations or treatment:**

Reason for treatment

Date

Doctor / Hospital

• **Medical Problems (for example, high blood pressure, arthritis, etc.)**

Social Issues:

- What is/ was your occupation _____
- What sort of hazardous duties or chemical exposures do/did you have at work?

- Have you had any military service? If yes, dates and branch: _____
- Who lives in your home? (please list name, age, and relationship)

- What assistive devices do you use? (cane/wheelchair/other?) _____
- Hobbies/ Things You Enjoy: _____
- Do you now use, or have you ever used any of the following? (for each item checked, please indicate how much and/or how often you have used it):
 - Alcohol _____
 - Cigarettes _____
 - Cigars/Pipes _____
 - Smokeless Tobacco (chew, snuff) _____
 - Marijuana or other drugs _____
 - IV Drugs _____
- What is your religious affiliation, if any? _____
- What is your sexual preference?
 Heterosexual Homosexual Bi-Sexual
- Do you have experience with any sexual dysfunction? (pain during sex, etc.)?

- Have you ever been concerned you might have HIV (the AIDS virus)? If so, why?

- Do you have any pets? _____

Family History:

- List the ages and health problems of the **blood relatives** listed below. If a family member is no longer living, give cause of death and age at death.

Mother: _____

Father: _____

Brother and Sisters: _____

Children: _____

- For the diseases or conditions listed below, please check any or all boxes that apply to your **blood relatives**. In the blanks, please write the relationship and age if known.

Heart Attack, bypass surgery, or balloon procedure? _____

Heart valve or rhythm problem? _____

Stroke or bleeding in the brain? _____

Alzheimer's or other cause of dementia? _____

Alcohol or drug abuse? _____

Suicide? _____

Severe depression or other mental disorder? _____

Glaucoma? _____

Migrane headaches? _____

Breast cancer? _____

Colon cancer? _____

Female cancer (ovary, cervix, uterus)? _____

Melanoma or other skin cancer? _____

Excessive bleeding or bruising? _____

Genetic disease? _____

High blood pressure? _____

Prostate cancer? _____

Asthma? _____

Inflammatory diseases (rheumatoid arthritis, lupus)? _____

Tuberculosis (TB)? _____

High cholesterol? _____

Thyroid gland problems? _____

Diabetes mellitus (high blood sugars)? _____

Blood clots (in legs, lungs, etc.)? _____

Preventive Medicine:

• How often do you wear your seatbelt? _____

• What is your cholesterol level? _____

• When was your last TB test? _____ Result? _____

• When was your Tetanus Shot? _____

• When was your last stool blood test? _____ Result? _____

• When was your last breast self-exam? _____

When was your last Pap smear? _____ Result? _____

• When was your last mammogram? _____ Result? _____

Diet and Exercise:

- How many times per week do you eat/drink:

Red meat? _____

Fresh Fruit and Vegetables? _____

Fried Foods? _____

Dessert Foods? _____

Milk/ Dairy Products? _____

- What, if any, dietary supplements (vitamins, minerals, herbal remedies) do you take?

- Have you tried to lose weight in the past 6 months? What did you try?

- Do you get any regular exercise? (list what type and how often)

- When exerting yourself, what makes you stop?

Nothing

Shortness of Breath

Chest Pain

Dizziness

Leg Cramps

Joint or Back Pain

- How far can your walk without stopping?

Less than 1 block

1-3 blocks

3 or more blocks

Comments or Concerns: _____

Signature

Date