Androscoggin Valley Hospital
North Country Home Health & Hospice Agency
Upper Connecticut Valley Hospital
Weeks Medical Center

WMC ADULT DATA BASE

PERSONAL HISTORY	Name:	Birthdate:
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced		Home phone #:
Occupation: Current Retired		Work phone #:
Education: (years)	Insurance:	Religion:

Number of pregnancies: Full Term ____ Miscarriages ____ Premature ____ C-Sections ____ Terminations ____ Stillbirths ____

Children/Year of Birth:

Who lives in household with you?

Nearest relative (name/relation/phone number):

FAMILY HISTORY	Year of Birth	Major health problems (if deceased, include cause of death)
Mother		
Father		
Brothers/Sisters		

Circle any of the following disease which a blood relative has had

1. Heart Attacks	5. Rheumatic Fever	9. Goiter (thyroid)	13. Bleeding Disorder	17. Other:
2. High blood pressure	6. Tuberculosis	10. Epilepsy	14. Nervous Breakdown	
3. Diabetes	7. Arthritis	11. Liver Disease	15. Cancer	
4. Stroke	8. Gout	12. Kidney Disease	16. Anemia/low blood	

PAST MEDICAL HISTORY	DATE	OPERATION/ILLNESS	HOSPITAL OR PROVIDER
OPERATIONS			
HOSPITALIZATIONS			
INJURIES/FRACTURES			

MAJOR ILLNESSES: *Circle any of the following that you may have had*

1. Stroke	9. Rheumatic Heart Disease	17. Asthma	25. Diabetes	33. Urine Infections
2. Seizure	10. High Blood Pressure	18. Pneumonia	26. Jaundice	34. Venereal Disease
3. Mental illness	11. Heart Murmur	19. Seasonal Allergies	27. Ulcers	35. Thyroid Disease
4. Depression	12. Heart Attack	20. Anemia	28. Diverticulitis	36. Skin Conditions
5. Anxiety	13. Heart Failure	21. Bleeding Disorder	29. Gallbladder	37. HIV/AIDS
6. Cataracts	14. Angina	22. Blood Clots	30. Irritable Bowel	38. Epilepsy
7. Glaucoma	15. Tuberculosis	23. Arthritis	31. Kidney Stones	
8. Cancer	16. Emphysema	24. Gout	32. Kidney Infections	

IMMUNIZATIONS: *(list year of last dose)*
Tetanus Shot _____
Flu Shot _____
Pneumonia shot _____
Hepatitis A _____
Hepatitis B _____
Other: _____

SCREENING EXAM: *(list year done)*

TB Skin Test _____ Chest X-Ray _____ Breathing Test (Spirometry) _____
Heart EKG _____ Other X-Ray _____ Sigmoidoscopy _____
Pap Smear _____ Stool Test for Blood _____ Colonoscopy _____ Hearing Test _____
Mammogram _____ Cholesterol Test _____ Vision Test _____

PATIENTDOC

AFFIX PATIENT LABEL

Medications: *Please list all your current medications, including all over-the-counter medications such as aspirin, Tylenol, vitamins, cold medicines and alternative medicines such as herbs*

Name of Medication	Dose	Times Per day

Allergies: *Please list any medications, foods or other substances you are allergic to, or which caused major side effects. Include the type of reactions.*

Allergies	Reactions

IF YOU HAVE NO KNOWN ALLERGIES, CHECK HERE ☐

OTHER INFORMATION:

Smoking	Do you smoke?	☐ Yes ☐ No	*If Yes,* How much? _____	Would you like to quit?	☐ Yes ☐ No
	Have you ever smoked?	☐ Yes ☐ No	*If Yes,* When did you quit? _____		
Alcohol	Do you drink?	☐ Yes ☐ No	*If Yes,* How much? _____	Would you like to quit?	☐ Yes ☐ No
Exercise	Do you exercise?	☐ Yes ☐ No	*If Yes,* How much? _____		
			What types of exercise? _____		
Safety	Do you wear your seatbelt?	☐ Yes ☐ No			
	A helmet if you ride?	☐ Yes ☐ No			
Advanced Directives	Do you have any Advanced Directives?	☐ Yes ☐ No	*(Living Will/Durable Power of Attorney?)*		

PATIENT'S SIGNATURE: _____ **DATE:** _____

AFFIX PATIENT LABEL