South Shore
Medical Center

Adult Patient History Follow-Up Form

Patient Label

Please help us continue to provide you with quality care by answering the questions below. *Thank you!*

Patient's Name:	Date of Birth:	E-mail Address:
Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Cohabitating		
Education: ❑ Elementary ❑ High School ❑ College ❑ Graduate School		
Number of Children:		
Do you currently live in a shelter or have no steady place to sleep at night? ❑ Yes ❑No		
Form completed by: ❑ Self ❑ Husband/wife ❑ Mother/Father ❑ Daughter/Son ❑ Other:		

Do you have any problems you would like to discuss with your provider today? ❑ No ❑ Yes If yes, please explain:

SINCE YOUR LAST PHYSICAL EXAM have there been any changes to your medical or mental health status?
❑ No ❑ Yes If yes, please explain:

SINCE YOUR LAST PHYSICAL EXAM have you had an eye exam performed outside SSMC?
❑ No ❑ Yes If yes, please provide date and location.

SINCE YOUR LAST PHYSICAL EXAM have you had any allergic or adverse reactions to medications?
❑ No ❑ Yes If yes, please explain:

SINCE YOUR LAST PHYSICAL EXAM are you taking any new medications including those prescribed by other providers, over-the-counter medications or herbal remedies? ❑ No ❑ Yes If yes, please list and include doses if known.

SINCE YOUR LAST PHYSICAL EXAM have there been any changes in your family history?
❑ No ❑ Unknown ❑ Yes If yes, please explain:

SINCE YOUR LAST PHYSICAL EXAM have you had any Foreign Travel? ❑ No ❑ Yes	Do you have any planned Foreign Travel? ❑ No ❑ Yes If yes, please describe:
SINCE YOUR LAST EXAM has there been any change in your tobacco, alcohol or drug use history: ❑ No ❑ Yes If yes, please explain:	**SINCE YOUR LAST EXAM** has your occupation changed: ❑ No ❑ Yes If yes, please explain:

PLEASE COMPLETE BOTH SIDES OF THIS FORM

SEXUALITY			
Are you sexually active?	❑ Yes	❑ No	❑ Not currently
Sexually active with:	❑ Men	❑ Women	❑ Both
Birth control method?		# of partners in last 5 yrs:	
Do you have concerns about your sex life? ❑ No ❑ Yes			

FOR WOMEN ONLY				
Date of last menses?	# pregnancies	# deliveries	# abortions	# miscarriages
Date and location of last Pap smear? (if performed outside of SSMC)		Date and location of last mammogram? (if performed outside of SSMC)		

ACTIVITIES OF DAILY LIVING AND OTHER CONCERNS		
Have you had blood transfusions?	❑ No	❑ Yes
Are you exposed to hazardous materials at work?	❑ No	❑ Yes
Do you have difficulty sleeping?	❑ No	❑ Yes
Are you experiencing stress, anxiety, or depression?	❑ No	❑ Yes
Are you feeling satisfied with your weight?	❑ No	❑ Yes
Are you on a special diet?	❑ No	❑ Yes
Do you feel threatened, hurt or afraid in a relationship?	❑ No	❑ Yes
Do you or anyone in your home own a gun?	❑ No	❑ Yes
Do you exercise regularly?	❑ No	❑ Yes
If you ride a bike, do you wear a helmet?	❑ No ❑ N/A	❑ Yes
Do you wear a seat belt?	❑ No	❑ Yes
Do you do monthly self-exams (breast/testicular)?	❑ No	❑ Yes
Do you have a carbon monoxide detector in your home?	❑ No	❑ Yes
Do you have an Advance Directive or HealthCare Proxy? *If yes and SSMC does not have a copy, please send it to us or bring it in at your next visit.*	❑ No	❑ Yes

Patient Signature:		Date:	
OFFICE USE ONLY	Reviewed by:	Date:	

♦ Thank you for helping us to better care for you ♦