Cayuga Family Med	licine Initial Informa	ation Form for A	Adults (June 20	17) Today's	Date
NameYour occupation MaleFemale		M 1	Date of Birth_	D:1	Age
Mole Female	Transcandar	Marrieu	Single	Divorced	Otner
Portner's name and a	Transgender	_ Omei			
Partner's name and of	drang If was als				
Do you have any chil			imes and ages _		
Are there other family			14	1.:	-9 W N-
way we leave detaile	d messages regarding	lab and Aray re	suits on your an	swering machine	e? Yes No
What would you like	to discuss today? Ar	e you having any	y symptoms or p	roblems? Do yo	ou need any specific tests?
Past Medical past.	History - Please list	any hospitalizati	ions, surgeries, c	or medical probl	ems you have had in the
Please list all medicat	tions and doses, herbs	, vitamins, and s	upplements you	are taking more	e often than once a week.
Have you had any all	ergies or reactions to	any medications	? No Yes_	If yes, list the	he medicine and reaction.
Sigmoidoscopy Please list previous m	Colonoscopy Cl				
For women only: La	ast menstrual neriod	Are vou	using birth con	trol? No Ye	s Tyne
Number of pregnanci	es Live Births	Year last mami	mogram?	Year last nan s	mear?
Have you ever had ar	abnormal pap smear	? No Yes	If ves when?	What was	done?
					mily members has had the
disease. Please put th	ne age of the earliest of	liagnosis (for exa	ample –father ha	d his first heart	attack in his late 50s).
Illness	Self Father Mother	Brother Sister	Son Daughter	Grandmother G	randfather Aunt Uncle
High Blood Pressure					
High cholesterol					
Angina/Heart Attack					
Diabetes					
Breast Cancer					
Prostate Cancer					
Colon Cancer					
Other cancer					
Alcoholism					
Depression					
Other Mental Illness					
Asthma, Allergies, Ecsema					
Blood clots/phlebitis					
Thyroid problems					
Osteoporosis					
Other					

See other side

Social History					
Do you smoke now? NoYes H	How many packs per day? Ever try to quit?				
Did you ever smoke NoYes I	f yes, when and how many packs per day?				
Do you drink alcohol? NoYes I	How many drinks per week? Was alcohol ever a problem in the past?				
Marijuana? NeverPastCurrent	Cocaine? NeverPastCurrent Other Drugs?				
Sexual history – Active Yes No	Partners – Male Female Both Any concerns?				
Number of years with current partner Do you feel safe in your current relationship?					
What kinds of exercise do you do?	How much and how often?				
How healthy do you feel your eating patterns are right now?					
How stressed are you with life right now? What kind of stressors are you facing?					