



Adult Health Assessment
University Health Services
University of Massachusetts
 Amherst, MA 01003-9288
 413-577-5000
 Tax ID # 04-3167352

**L
A
B
E
L**

IDX MRN # _____
 Last _____ First _____ M _____
 DOB _____ Sex _____ Time _____
 DOS _____ Clinic _____
 Visit # _____ Provider _____

Please take a moment to answer a few questions about your health. Please use ink, sign, and date. Thanks.

Reason for Visit/Concerns you would like to discuss: _____

Drug Allergies and/or Medication Sensitivities: _____

Environmental and Food Allergies: _____

Current Medications: Please list all medications — including hormones, vitamins, over-the counter medications, creams, inhalers, & herbal preparations along with dosage. Check here if none.

Past Medical Problems: Hospitalizations, Surgery, & Serious Illness (Please include year)

Medical History: Have you ever had any of the following problems? Check if yes.

✓	MEDICAL CONDITION	✓	MEDICAL CONDITION	✓	MEDICAL CONDITION	✓	MEDICAL CONDITION
	Abnormal Pap Smear		Depression/Anxiety		High Blood Pressure		Sexual Infection
	Alcohol/Drug Problem		Diabetes		Kidney Disease		Sickle Cell Anemia
	Anemia		Ear Problems		Liver Disease		Sinusitis
	Arthritis		Eating Disorder		Mononucleosis		Stomach Problems
	Asthma		Emotional Problems		Orthopedic Problems		Thyroid Condition
	Back Problems		Hay fever		Pelvic Infections		Tuberculosis
	Bowel Disease		Headaches		Phlebitis/Blood Clots		Urinary Infections
	Cancer		Heart Disease		Pneumonia		Weight Changes
	Epilepsy		Hepatitis		Radiation Treatment		Other:



**Adult Health Assessment
University Health Services
University of Massachusetts**
Amherst, MA 01003-9288
413-577-5000
Tax ID # 04-3167352

L IDX MRN # _____
A Last _____ First _____ M _____
B DOB _____ Sex _____ Time _____
E DOS _____ Clinic _____
L Visit # _____ Provider _____

Family History: Please note any family members with medical problems such as heart disease, diabetes, cancer or other serious illnesses: _____

Lifestyle Review:

	YES	NO	COMMENTS
Do you drink caffeinated beverages? Coffee, Black Tea, Colas			
Do you use tobacco products? (Cigarettes, cigars, snuff/chewing tobacco)			
Do you drink alcohol?			
Do you usually drink more than 4 or 5 drinks in one social session?			
Have you felt you ought to cut down on your drinking?			
Do you use marijuana, or any other street or recreational drugs? If so, what kind?			
Do you do any regular physical activity? What type and how often?			
Have you lived or traveled outside the USA in the last two years? If so, where?			
Do you have concerns regarding sex, gender orientation, sexually transmitted infections or pregnancy prevention?			
Would you like to discuss these concerns with a health care provider?			

Stress/Emotional Health:

	YES	NO
In the past year, have you had any major changes or problems?		
Major change/problem (e.g. Personal/family relations, finances, job):		
Are you currently under treatment for clinical depression either in counseling or with medications?		
Have you felt sad, anxious or depressed much of the time in the past year?		
Has anyone ever sexually, physically, or emotionally abused you? (e.g. repeated hitting, calling of names, or loud criticism; childhood sexual touching by someone older than you; or rape)		
Are there other stress/emotional concerns you would like to discuss?		

Other concerns you would like to discuss including any social, cultural, religious, or gender related issues?

Name (signature)

Date

Health Care Provider, MD, NP, PA