Adult Health & Learning Accommodation Assessment
University Health Services
University of Massachusetts
Amherst, MA 01003-9288
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LABEL

Last Name:_____ MRN # _____
First Name:_____ MI:
DOB:_____ Sex:
Date of Service:_____ Visit #: _____
Provider:_____

This information will assist your provider at the time of your clinic visit and become part of your confidential medical record. It will not be viewed before that time.

Preferred name:

Drug allergies and/or medication sensitivities:

Environmental and/or food allergies:

Current medications: List all medications, including hormones, vitamins, over-the-counter medications, creams, inhalers, and herbal remedies, along with dosage. ❑ Check here if none.

Past medical problems: Hospitalizations, surgeries and serious illnesses, including year.

Family history: List any family members with medical problems such as heart disease, diabetes, cancer or other serious illnesses.

Medical history: Check any of the following which you have ever had.

✓	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:

(Continued on reverse)

Lifestyle review:

	Yes	No	Comments
Do you drink caffeinated beverages such as coffee, black tea or cola?			
Do you use tobacco products (cigarettes, cigars, e-cigs, 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? If so, what type and how often?			
Have you lived or traveled outside the U.S. in the last 2 years? If so, where?			
Are sexually transmitted infections or pregnancy prevention a concern?			

Stress/emotional health:

Have you experienced major changes or problems in the past year (e.g. personal or family relationships, finances, job)? If so, please list:		
Are you currently under treatment for clinical depression, either in counseling and/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 (including repeated hitting, name-calling or loud criticism; childhood sexual touching by someone older than you; or rape)?		
Would you like to discuss stress/emotional concerns?		

Advance directive: An advance directive in a legal document you create which allows you to make your medical decisions known to others. It also allows you to appoint someone you trust to make those decisions for you. Do you have an advance directive? ❑ Yes ❑ No

If yes, bring a copy to your first UHS visit. If you do not have an advance directive, but want to create one, forms are available at UHS.

I have the following learning needs: Please help us understand your disability or learning accommodation needs. ❑ Check if none.

_____

_____

_____

Things I would like my healthcare provider to know about me: ❑ Check if none.

❑ Gender identity:

_____

❑ Sexual orientation:

_____

Patient signature: _____ **Date:** ___/___/__