



Today's Date: _____
Provider: _____

Name: (last) _____ (first) _____ Date of Birth: _____
 Mail Order Pharmacy: _____ Phone: _____ Fax: _____
 Local Pharmacy: _____ Phone: _____ Fax: _____
 Language Spoken at home: _____

MEDICATIONS:

Please list all medications (include over-the-counter?)
 In preparation for your visit bring all medications, inhalers,
 vitamin or supplements in their original bottles.

NAME	STRENGTH	FREQUENCY
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		

ALLERGIES:

Are you allergic to any drugs or medications?

NO YES If yes, what?

Do you have any food allergies?

NO YES If yes, what?

Any other allergies?

NO YES If yes, what?

PAIN:

Are you having pain today? NO YES

If yes, on a scale of 1-10

1 = little or no pain and 10 = severe pain

What level are you at? _____

REVIEW OF SYSTEMS: Please check any symptoms you have had RECENTLY

Constitutional

- Chills
- Fatigue
- Fever
- Night sweats
- Weight gain
- Weight loss

HEENT

- Ear drainage
- Ear pain
- Eye discharge
- Eye pain
- Hearing loss
- Nasal drainage
- Sinus pressure
- Sore throat
- Visual changes

Respiratory

- Cough
- Shortness of breath
- Wheezing

Cardiovascular

- Chest pain
- Leg pain when walking
- Edema (swelling)
- Palpitations

Gastrointestinal

- Abdominal pain
- Blood in stool
- Change in stool
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Vomiting

Genitourinary

- Painful urination
- Blood in urine
- Urinary frequency
- Urinary incontinence

Skin

- Hair loss
- Hives
- Itching
- Mole changes
- Rash
- Skin lesion

(Female Only)

- Breast discharge
- Breast lump
- Breast pain

Reproduction

(Female Only)

- Abnormal Pap
- Painful period
- Painful intercourse
- Hot flashes
- Irregular menses
- Vaginal discharge

Last Period _____

(Male Only)

- Erectile dysfunction
- Penile discharge

Neurological

- Dizziness
- Extremity numbness
- Extremity weakness
- Gait disturbance
- Headache
- Memory loss
- Seizures
- Tremors

Psychiatric

- Anxiety
- Depression
- Insomnia

Metabolic/Endocrine

- Cold intolerance
- Heat intolerance
- Excessive thirst
- Excessive hunger

Musculoskeletal

- Back pain
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain

Hematologic/Lymphatic

- Easy bleeding
- Easy bruising
- Enlarged lymph nodes

Immunologic

- Contact allergy
- Environmental allergies
- Food allergies
- Seasonal allergies

Name: _____ DOB: _____

In the last 2 weeks have you felt down, depressed or hopeless? (circle one)

Not at all Several Days More than ½ the days Every Day

Had little or no interest in doing things? (circle one)

Not at all Several Days More than ½ the days Every Day

CHRONIC CONDITIONS: Please mark any illness or disease you have had in the past or currently have:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Kidney disease | Other-Specify _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Arthritis
Specify _____ | <input type="checkbox"/> Gall bladder disease | | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Headache, migraine | | <input type="checkbox"/> Neck/Back Problems |
| <input type="checkbox"/> Benign prostatic hypertrophy | <input type="checkbox"/> Heart disease | | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Heart valve disorder | | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Cancer
Type _____ | <input type="checkbox"/> Hepatitis/liver disease | | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Cardiac arrhythmia | <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Gout |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Irritable bowel syndrome | | <input type="checkbox"/> Chronic Insomnia |
| | <input type="checkbox"/> Heart Attack | | <input type="checkbox"/> Psychiatric Illness |
| | <input type="checkbox"/> Osteoporosis | | |

SURGICAL/HOSPITALIZATION HISTORY: (if marking an item below please include the year it occurred)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> LASIK | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall Bladder Removal | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Bladder suspension |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> Colectomy | <input type="checkbox"/> Myomectomy | <input type="checkbox"/> Cervix Surgery |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Colostomy | <input type="checkbox"/> ORIF (Fracture surgery) | <input type="checkbox"/> Liver Biopsy |
| <input type="checkbox"/> Bilateral Tubal Ligation | <input type="checkbox"/> D and C | <input type="checkbox"/> Thyroidectomy | <input type="checkbox"/> Prostate Biopsy/Surgery |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Hernia Repair | | <input type="checkbox"/> Breast Reduction |
| <input type="checkbox"/> CABG (Bypass surgery) | <input type="checkbox"/> Hip Replacement | | <input type="checkbox"/> Breast Biopsy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hysterectomy | | |
| <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Knee Replacement | | |

What diagnostic, screening studies or immunizations have you had done previously? Please list most recent date.

- | | | |
|---------------------------|-------------------------------------|---------------------------------|
| Complete Physical _____ | Last PAP _____ | Tetanus/Td/Tdap Vaccine _____ |
| Cardiac Stress Test _____ | Last Mammogram _____ | Pneumonia Vaccine _____ |
| Colonoscopy _____ | Bone Density (DEXA) _____ | Zostavax/Shingles Vaccine _____ |
| Cholesterol _____ | Have you had the chicken pox? _____ | Hepatitis A Vaccine _____ |
| Last Eye Exam _____ | Flu Vaccine _____ | Hepatitis B Vaccine _____ |
| Last Dental Exam _____ | | |

Name: _____ DOB: _____

FAMILY HISTORY: Check below to report problems your family members have had. Please state age when they had the problem if you know it.

Adopted (unknown family history)

	Mother	Father	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Sister	Brother	Child
ADD/ADHD									
Alcoholism									
Alzheimer's disease									
Arthritis (Rheumatoid)									
Asthma									
Blood disorder /Clotting									
Cancer (list type)									
Heart Disease									
Depression									
Diabetes									
Genetic disease									
High Blood Pressure									
Inflammatory Bowel Syndrome									
Mental Illness									
Migraines									
Obesity									
Osteoporosis									
Seizure disorder									
Stroke									
Thyroid disorder									
Aneurysm									
Elevated Cholesterol									
Other									
Deceased? Age?									

Name: _____ DOB: _____

SOCIAL HISTORY:

Tobacco Usage: No Yes Quit Type? _____ If yes or quit, how long? _____ Packs per day? _____

Alcohol Usage: No Yes Quit Type? _____ How Much? _____

Caffeine Usage: No Yes Quit Type? _____ How Much? _____

Drug Usage: No Yes Quit Type? _____ How Much? _____

Occupation: _____ Employed? Employer _____

Military Experience: No Yes Current status: active reserves discharged retired military

Marital Status: Married Single Life Partner Divorced Widowed If married, spouses name: _____

Do you have any children? No Yes
of sons _____ # of daughters _____
of stepsons _____ # of stepdaughters _____
of adopted sons _____ # of adopted daughters _____

What is your activity level? Moderate Sedentary Vigorous

Exercise Type: _____ Frequency? 2-3 times/week 3-4 times/week daily never occasional

Do you have a religious affiliation? No Yes Affiliation: _____

Smoke Detectors in home? No Yes Do you wear seat belts? No Yes

Carbon Monoxide Detectors in home? No Yes Firearms at home? No Yes

Radon in home? No Yes Treated Untreated

Are you sexually active? No Yes Not currently

Please list all specialty Physicians that you have seen in the last year:

Provider Name: _____
Specialty: _____
Phone Number: _____
Reason/Diagnosis: _____

Provider Name: _____
Specialty: _____
Phone Number: _____
Reason/Diagnosis: _____

Provider Name: _____
Specialty: _____
Phone Number: _____
Reason/Diagnosis: _____

Provider Name: _____
Specialty: _____
Phone Number: _____
Reason/Diagnosis: _____

The above information is correct to the best of my knowledge.

Signature of Patient/Parent/Legal guardian/Patient advocate/Next of kin – circle one

Date