Patient Name: ______________________ Date of Birth: ______________________

Date: ______________________

1. What is the reason for todays visit?

____

____

2. Please place a check mark next to any symptoms you may have had over the last 2 weeks.

Constitutional		Eyes		Gastrointestinal		Endo/Heme/Allergy	
Fever		Blurred Vision		Heartburn		Easily bruise/bleed	
Chills		Double Vision		Nausea		Allergies	
Weight Loss		pain with light		Vomiting		Ex thirst (Polydipsia)	
Fatigue (Malaise)		(photophobia)		Abdominal pain		**Neurological**	
Excess perspiration		Eye pain		Diarrhea		Dizziness	
(Diaphoresis)		Eye discharge		Constipation		Tingling	
Weakness		Eye redness		Blood in stool		Tremor	
Skin		**Cardiovascular**		Black stools		Sensory change	
Rash		Chest pain		(Melena)		Speech change	
Itching		Palpitations		**Genitourinary**		Focal weakness	
HENT		Shortness of breath		Painful urination		Seizures	
Headaches		when laying flat		(dysuria)		Loss of	
Hearing loss		(Orthopnea)		Urgency		consciousness (LOC)	
Ringing in ears		Pain in legs-walking		Frequent urination		**Psychiatric**	
(Tinnitus)		Due to poor circulation		Blood in urine		Depression	
Ear pain		Leg Swelling		(Hematuria)		Suicidal ideas	
Ear discharge		Sudden shortness of		Flank (side) pain		Substance abuse	
Nosebleed		breath in sleep (PND)		**Musculoskeletal**		Hallucinations	
Congestion		**Respiratory**		Muscle pain		Nervous/Anxious	
High pitched sound		Cough		(Myalgia's)		Insomnia	
during breathing in							
neck or throat (Stri)		Coughing up blood		Neck pain		Memory loss	
Sore throat		(Hemoptysis)		Back pain			
		Sputum production		Joint pain			
		Shortness of breath		Falls			
		Wheezing (Lungs)					

3. Please list any medications that you would like refilled and your preferred pharmacy:

____

____

4. Please list any referrals you may need:

____

____

Revised 03/21/14

Patient Name: ______________________________ Birth Date: ____________________

MEDICATION AND ALL OTHER ALLERGIES

Please list your allergies, adverse reactions, or side-effects to medications you have experienced:

CURRENT MEDICATIONS

Name	Strength	Dose	Reason

PAST MEDICAL HISTORY

Addison's Disease?	Yes	No	Congestive Heart Failure?	Yes	No	Heart Attack	Yes	No	Parathyroid Disorder?	Yes	No
Adrenal Disorder?	Yes	No	Clotting Disorder?	Yes	No	Heart Murmur?	Yes	No	Pituitary Disease?	Yes	No
Allergies?	Yes	No	Chronic Obstructive Pulmonary Disease?	Yes	No	HIV/AIDS?	Yes	No	Seizures?	Yes	No
Anemia?	Yes	No	Cushing's Syndrome?	Yes	No	Hyperlipidemia?	Yes	No	Sickle Cell?	Yes	No
Anxiety?	Yes	No	Depression?	Yes	No	Hypertension?	Yes	No	Stroke?	Yes	No
Arrhythmia?	Yes	No	Diabetes Mellitus?	Yes	No	Inflammatory Bowel?	Yes	No	Substance Abuse?	Yes	No
Arthritis?	Yes	No	Diabetic Neuropathy?	Yes	No	Kidney Disease?	Yes	No	Thyroid Disease?	Yes	No
Asthma?	Yes	No	Acid Reflux?	Yes	No	Meningitis?	Yes	No	Tuberculosis?	Yes	No
Blood Transfusions?	Yes	No	Glaucoma?	Yes	No	Migraine?	Yes	No	Ulcer?	Yes	No
Cancer?	Yes	No	Goiter?	Yes	No	Nerve/Muscle Disorder?	Yes	No	Urinary Tract Infections?	Yes	No
Cataracts?	Yes	No	Headache	Yes	No	Osteoporosis?	Yes	No		Yes	No

SURGICAL HISTORY

Abdominal Surgery?	Yes	No	Cholecystectomy?	Yes	No	Joint Replacement?	Yes	No	**Other:**		
Appendectomy?	Yes	No	Colon Surgery?	Yes	No	Prostate Surgery?	Yes	No	Other:	Yes	No
Brain Surgery?	Yes	No	Eye Surgery?	Yes	No	Small Intestine Surgery?	Yes	No	Other:	Yes	No
Coronary Artery Bypass (CABG)	Yes	No	Fracture Surgery?	Yes	No	Spine Surgery?	Yes	No	Other:	Yes	No
Cardiac Valve Replacement	Yes	No	Hernia Repair?	Yes	No	Vasectomy?	Yes	No	Other:	Yes	No

Patient Name: ______________________________ Birth Date: ______________

FAMILY HISTORY

Please place a check mark under each disease that pertains to each family member.
Please add any additional diseases or relatives as needed to "Add:"

Relationship	Alive?		Age at death	Arthritis	Lung DZ	Genetic	Cancer	Psychiatry	Diabetes	Heart DZ	Hypertension	Hyperlipidemia	Stroke	Alcohol/Drug	Add:	Add:
Mother	Yes	No														
Father	Yes	No														
Sister	Yes	No														
Brother	Yes	No														
Maternal Aunt	Yes	No														
Maternal Uncle	Yes	No														
Paternal Aunt	Yes	No														
Paternal Uncle	Yes	No														
Maternal GM	Yes	No														
Maternal GF	Yes	No														
Paternal GM	Yes	No														
Paternal GF	Yes	No														
Add:	Yes	No														
Add:	Yes	No														
Add:	Yes	No														
Add:	Yes	No														
Add:	Yes	No														

SOCIAL HISTORY

Tobacco use:
Never Smoked _____
Previous Smoker_____
Current Smoker_____

Type of tobacco used: ☐ Cigarettes ☐ Pipe ☐ Cigars
Packs/Day ☐ 0.25 packs ☐ 0.5 packs ☐ 1 pack
☐ 1.25 packs ☐ 1.5 packs ☐ 2 packs
Number of year of use:

Smokeless Tobacco:
Never used _____
Previously used_____
Currently use_____

Other types: ☐ Snuff ☐ Chew

Ready to Quit? Yes No Comment:

Alcohol Use? Yes No Comment: ______________
Drinks/Week
_____ Glasses of wine
_____ Cans of beer
_____ Shots of liquor
_____ Drinks containing 0.5 oz of alcohol

Drug Use? _____ Yes _____ No Comment: ______________
Number of times per week: _____ Types: ______________

Sexually Active? _____ Yes _____ No _____ Not Currently
Partners: _____ Female _____ Male Comment: ______________
Birth Control/Protection (Check all that apply):
___ Abstinence ___Coitus interruptus ___ Condom ___ Diaphragm ___ implant ___Injection
___ Inserts ___IUD ___ Pill ___ Patch ___ Post Menopausal ___Rhythm ___ Spermicide
___ Sponge ___ Surgical ___ Other - See Comments.

Patient Name: ______________________________________ Birth Date: ____________________

SOCIAL HISTORY

Question	No	Yes
Have you served in the Military? If yes please explain:	No	Yes
Have you ever received a blood transfusion? If yes please explain:	No	Yes
Do you drink caffeine? If yes how many cups how often?	No	Yes
Do you have any occupational Exposures? If yes please explain:	No	Yes
Do you have any hobby hazards such as exposure to the sun? If yes please explain:	No	Yes
Do you have any sleep concerns? If yes please explain:	No	Yes
Do you have any stress related concerns? If yes please explain:	No	Yes
Do you have any weight related concerns? If yes please explain:	No	Yes
Are you on a special diet? If yes please explain:	No	Yes
Do you have any questions regarding back care? If yes please explain:	No	Yes
Do you exercise regularly? If yes please explain:	No	Yes
Do you wear a helmet while riding a bike? Comments:	No	Yes
Do you use seat belts? Comments:	No	Yes
Do you perform self-examinations regularly? Comments:	No	Yes

SOCIOECONOMIC

Family

What is your current Marital Status?

Education

Years of education?

If married what is your spouse's name?

Number of Children and ages?

Ethnicity:

Language:

Race: