

Name: _____ DOB: _____ Age: _____ Date: _____

What issues concerning your health would you like to discuss today? _____

Drug Allergies: _____

Food / Material Allergies (include Latex): _____

Medical History: Have you ever had or been diagnosed to have: Check all that apply below

- | | | |
|---|---|--|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteopenia |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes/Pre-Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Jaundice/Liver Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> TB/Lung Disease | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer: What kind? | <input type="checkbox"/> Prostate Problems | |
| | <input type="checkbox"/> Kidney Disease | |

List any other medical problems (not previously listed) below:

List Previous Hospitalizations and Surgeries Below:				Name of any other doctors you see:	
What / Where	Date	What / Where	Date	Name	Specialty

Medications: List all medications you take regularly, including herbal / OTC medicines

Medication Name	Strength	Daily Frequency	Medication Name	Strength	Daily Frequency

Health Maintenance: (if you've had the test done, please list when last performed):

- | | | |
|---|--|--|
| <input type="checkbox"/> Bone Density Test _____ | <input type="checkbox"/> Shingles Vaccine _____ | <input type="checkbox"/> Meningococcal Vaccine _____ |
| <input type="checkbox"/> Colonoscopy _____ | <input type="checkbox"/> Flu shot _____ | <input type="checkbox"/> Mammogram _____ |
| <input type="checkbox"/> Stool cards _____ | <input type="checkbox"/> Pneumonia Vaccine _____ | <input type="checkbox"/> Pap Smear (female only) _____ |
| <input type="checkbox"/> Diabetes screen _____ | <input type="checkbox"/> Tetanus shot _____ | <input type="checkbox"/> PSA (males only) _____ |
| <input type="checkbox"/> Cholesterol screen _____ | <input type="checkbox"/> Hep A Vaccine _____ | <input type="checkbox"/> Eye Exam _____ |
| <input type="checkbox"/> HPV Vaccine _____ | <input type="checkbox"/> Hep B Vaccine _____ | |

If you have a Vaccination Record, please provide that for your chart. YES NO

Patient Name: _____

DOB: _____

Family History (place an X by appropriate choice)

Family Member	High Blood Pressure	Diabetes	Heart Attack (what age?)	Asthma	Cancer (what kind?)	Stroke	Thyroid Problems	Other
Mother (Age____)								
Father (Age____)								
Siblings								
Grandparents								
Other								

Social History:

- Occupation: _____ If retired or disabled, from what? _____
- Marital Status: Single Married Divorced Widowed Other
- Number of children: _____ Number of persons in household: _____ Education through grade: _____
- Hobbies: _____
- Any Religious / Spiritual needs we should be aware of: _____
- Do you currently smoke? YES NO
- Did you smoke in the past? YES NO When did you quit: _____
- Cigarettes: _____ packs per day.....for: _____ years
- Did you ever smoke PIPES or CIGARS? YES NO How much: _____
- Do you use illegal/street drugs? YES NO Type: _____
- Have you ever used drugs (illegal/street)? YES NO Type: _____

 Do you drink alcohol? YES NO Family history of alcoholism YES NO

Type: _____ Quantity per week: _____

- Do you feel guilty about your drinking? YES NO
- Have you ever cut down on your drinking? YES NO
- Do people annoy you about your drinking? YES NO
- Do you ever drink alcohol in the morning? YES NO

 Any history of STD's? (sexually transmitted diseases) YES NO

Type(s): _____

 Do you have any sexual concerns? YES NO

The CDC recommends that everyone be screened for HIV. Do you have any concerns about possible exposure that you would like to discuss or be tested for? YES NO

- Exercise: Type(s): _____ Hours per week: _____
- Do you drink coffee, caffeinated tea or sodas regularly? YES NO #/day: _____
- Do you have a living will/advanced directive? YES NO (If yes, provide copy for your chart)
- Have you been a victim of physical or mental abuse? YES NO
- **If you do not feel safe in your home, please discuss with the doctor.**
- Do you use seatbelts in your automobile on a regular basis? YES NO
- Do you feel downhearted or blue, depressed or hopeless? YES NO
- Do you lack interest or pleasure in doing things you used to do? YES NO

Females Only:

 Age of first period: _____ Last menstrual period: _____ Are you pregnant? YES NO

How many of each: Pregnancies: _____ Full term births: _____ Preterm births: _____

Miscarriages: _____ Abortions: _____ Living children: _____ Vaginal births: _____ C-Sections: _____

 Have you ever had an abnormal pap smear? YES NO If yes, when: _____

Method of birth control (if applicable): _____

Patient Name: _____

DOB: _____

Review of Body Systems: Are you having problems with (check all that apply)
General:

- Unusual weakness
- Excessive fatigue
- Recent weight gain
- Recent weight loss
- Fevers, chills, sweats
- Loss of appetite

Eyes:

- Double or blurry vision
- Loss of vision
- Spots before your eyes
- Need for glasses/contacts
- Eye pain
- Red eye
- Itchy, watery eyes

Ears, Nose, Throat:

- Deafness/hearing aids
- Ringing in the ears
- Ear Pain
- Hay fever/allergies
- Frequent colds
- Post-nasal drainage
- Loss of smell
- Frequent sore throat
- Chronic hoarseness
- Bleeding gums or nose

Endocrine:

- Excessive thirst or urination
- Thyroid disorder
- Heat or cold intolerance

Respiratory:

- Difficulty swallowing
- Chronic cough
- Coughing up blood
- Shortness of breath

Hematologic/Oncology:

- Bleeding Disorder
- Increased bruising
- Excessive bleeding after cuts
- Enlarging lymph glands or nodes
- Unusual lump or mass

Cardiovascular:

- Chest pain or discomfort
- Swollen ankles, feet
- Heart murmur
- High blood pressure
- Low blood pressure
- Fainting spells
- Fast or irregular heart beat

Gastrointestinal:

- Recurring abdominal pain
- Vomiting
- Vomiting blood
- Bloody or black stools
- Diarrhea
- Constipation
- Difficulty swallowing
- Loss of appetite
- Frequent heartburn
- Change in appearance of stool

Genitourinary:

- Pain with urination
- Frequent need to urinate
- Blood in urine
- Urinary dribbling
- Leakage of urine
- Decreased force of urinary stream
- Waking up to urinate at night

Musculoskeletal:

- Painful joints
- Frequent muscle cramps
- Frequent / prolonged pain
- Joint infection
- Red, hot, swollen joints
- Arthritis

Neurologic:

- Paralysis
- Memory loss
- Numbness, weakness
- Dizziness / Vertigo
- Loss of balance
- Seizures / Epilepsy
- Inability to walk without assistance
- Frequent Headaches
- Frequent falls

Psychiatric:

- Anxiety
- Panic attacks
- Depression
- Difficulty sleeping

Skin:

- Pain
- Redness
- Rash
- Changing Moles
Location: _____

Female Only:

- Breast lump or pain
- Painful intercourse
- Bleeding after intercourse
- Too frequent periods
- Bleeding between periods
- Excessive flow with periods
- Unusual pain with periods
- Vaginal discharge
- Duration of periods ___days
- Cycle length (from start to start)_____days
- If menopausal, since age_____

Male Only:

- Difficulty with erections
- Lump on testicle
- Prostate trouble
- Genital discomfort