Date: ___________________

Patient Name: ____ **Date of Birth:** ___ / ___ / ___
(Last) (First) (Middle)

Name of Doctor Being Seen:

____

Preferred Pharmacy:

Name: ____

Address: ____

Phone: ____

Additional Physicians/Specialists You See Regularly:

Name: ___________________________ Specialty: ___________________ Location: _______________

Name: ___________________________ Specialty: ___________________ Location: _______________

Name: ___________________________ Specialty: ___________________ Location: _______________

Name: ___________________________ Specialty: ___________________ Location: _______________

REASONS FOR YOUR APPOINTMENT:

1. ____

2. ____

3. ____

PAST MEDICAL HISTORY: Please select your current medical conditions.

Hypertension (High Blood Pressure)	YES	NO
Diabetes (High Blood Sugar)	YES	NO
COPD (emphysema, chronic bronchitis)	YES	NO
High Cholesterol	YES	NO
Heart Disease	YES	NO
Anxiety	YES	NO
Depression	YES	NO
Thyroid Disorder	YES	NO

Please list your other medical conditions:

________________________ ________________________

________________________ ________________________

________________________ ________________________

MEDICATIONS: List your current medications. Include aspirin, birth control pills, nutritional supplements, and over-the-counter medicines you use regularly.

☐ Check here if you brought a medication list. Please give list to your nurse.

1. ____
Name of Medication Dosage Amount How Often Taken

2. ____
Name of Medication Dosage Amount How Often Taken

3. ____
Name of Medication Dosage Amount How Often Taken

4. ____
Name of Medication Dosage Amount How Often Taken

5. ____
Name of Medication Dosage Amount How Often Taken

6. ____
Name of Medication Dosage Amount How Often Taken

7. ____
Name of Medication Dosage Amount How Often Taken

8. ____
Name of Medication Dosage Amount How Often Taken

*Note: Please check here ☐ if you have additional medicines. Ask nurse for additional paper if needed.

ALLERGIES: Medication/Food Type of Reaction

1. ____

2. ____

3. ____

If needed, list additional allergies here: _______________________________________

PAST SURGICAL HISTORY: List your past surgeries.

1. ________________________________ Year ___________________
2. ________________________________ Year ___________________
3. ________________________________ Year ___________________
4. ________________________________ Year ___________________

PRIOR HOSPITALIZATIONS: List specific hospitals and reason for hospitalization.

1. _____________________________________ Month/Year ______________
2. _____________________________________ Month/Year ______________
3. _____________________________________ Month/Year ______________

FAMILY HISTORY:

List family members who have had the following:

Diabetes: ____
High Blood Pressure: ____
High Cholesterol: ____
Heart attacks: ____
Strokes: ____
Asthma/COPD: ____
HIV or AIDS: ____
Stomach/Colon Problems: ____
Psychiatric Disorders (i.e. anxiety, depression): ________________________
Bleeding Disorder or Anemia: ______________________________________
Cancer:

Relation | Type (i.e. breast, prostate, etc.)

____
____
____

List additional conditions you consider significant:_________________________

OB/GYN HISTORY: Please complete if female.

Number of Pregnancies: __________
Number of Miscarriages, Abortions, Stillbirths: __________
Do you currently use contraception/birth control? YES NO
If yes, what type? ___________________________________
Do you see an OBGYN regularly? YES NO If yes, whom do you see? _________________

PERSONAL HISTORY:

Occupation: ___________________________________
Education: *List highest level attained* ___________________________________
Marital Status: __________________________________
Spouse's Occupation: ____________________________
Children (include names and age):
___________________ ___________________ ___________________

PERSONAL HISTORY (continued):

Health Habits:

1. Alcohol use:
   - Do you drink alcohol? YES NO
   - How many drinks per week? ___________
   - Do you drink alcohol daily? YES NO
     - What type, how much? ___________
2. Smoking:
   - Are you are smoker? YES NO
   - If yes, how many packs per day? ____________
   - If a former smoker, what year did you quit? ____________
3. Illicit drug use (such as marijuana, cocaine, methamphetamines, etc.):
   - What type? ____________
   - How often? _____________
4. Exercise:
   - Do you exercise regularly? YES NO
5. Diet:
   - Are you satisfied with your diet? YES NO
   - How much water do you drink daily? ___________________
   - How many cups of coffee or tea per day? _______________
6. Sleep:
   - Hours of sleep per day ________________

PREVENTIVE CARE:

If applicable, please provide the approximate date of your last…

	Date	Obtained Where?
Pap Smear:	___________________________________	_________________________
Mammogram:	________________________________	_________________________
Colonoscopy:	_________________________________	_________________________
Eye Exam:	____________________________________	_________________________
Bone Density (DEXA) Scan:	_____________________	_________________________

Have you received the following immunizations?

			List Date if known:
Influenza/Flu	YES	NO	________________
Pneumonia	YES	NO	________________
Tetanus	YES	NO	________________
Pertussis	YES	NO	________________
HPV/Gardasil	YES	NO	________________
Hepatitis A	YES	NO	________________
Hepatitis B	YES	NO	________________
Shingles	YES	NO	________________

Patient Signature: ____ **Date:** ______________

Healthcare Provider Signature: ____________________________________ **Date:** ______________

REVIEW OF SYSTEMS:

Please place a checkmark next to any symptom you are currently experiencing:

General	Weight Loss ___ Weight Gain ___ Fever ___ Night Sweats ___ Fatigue ___ None____
Eyes	Blurry Vision ___ Loss of Vision ___ Eye Pain ___ Eye Redness ___ Dry Eyes ___ None ____
ENT	Sore Throat ___ Sinus Trouble ___ Hoarse Voice ___ Hearing Loss ___ Ringing in Ears ___ Ear Pain ___Tooth Problems ___ None____
Cardiovascular	Chest Pain ___ Rapid Heartbeat___ Murmur ___ Leg Swelling ___ Leg Pain when Walking ___ None_____
Respiratory	Shortness of Breath ___ Cough ___ Sputum Production ___ Coughing up Blood ___ None _____
Gastrointestinal	Nausea ___ Vomiting ___ Diarrhea ___ Constipation ___ Abdominal Pain ___ Blood in Stool ___ Frequent Heartburn ___ Trouble Swallowing ___ None _____
Genitourinary	Burning with Urination ___ Increased frequency ___ Urgency Incontinence ___ Blood in Urine ___ Erectile Dysfunction ___ Vaginal Discharge ___ Breast Lump or Pain ___ None _____
Musculoskeletal	Joint Pain ___ Muscle Pain ___ Muscle Weakness ___ Back Pain ___ None ____ *If so, list where:* ____
Endocrine	Increased Thirst ___ Excessive Sweating ___ Heat Intolerance ___ Cold Intolerance ___ Poor appetite ___ Irregular Menstrual Periods ___ None _____
Neurologic	Headaches ___ Tremor ___ Tingling/Numbness ___ Dizziness ___ Speech Difficulty ___ None____
Psychiatric	Anxiety ___ Depression ___ Panic Attacks ___ Alcohol/Drug Dependence ___ Suicidal Thoughts ___ Work/Home Life Unpleasant ___ None _____ *If you suffer from any of the above, do you desire psychiatric help: YES NO*
Hematologic/ Lymphatic	Easy Bruising ___ Swollen Lymph Nodes ___ None _____
Skin	Changes in Moles ___ Skin Problems ___ Rash ___ Itching ___ Hair Loss ___ None _____

Please list any additional symptoms you feel pertinent to your medical health:

________________ ________________ ________________ ________________ ________________

Patient Signature: ____ Date: ______________

Healthcare Provider Signature: ____________________________________ Date: ______________