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: _____

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

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

*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: _____

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

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 OB/GYN 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):
_____ _____ _____

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

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… Obtained Where?

Pap Smear: _____ _____

Mammogram: _____ _____

Colonoscopy: _____ _____

Eye Exam: _____ _____

Bone Density (DEXA) Scan: _____ _____

Prostate: _____ _____

PSA Screening: _____ _____

Have you received the following immunizations? List Date if known:

Influenza/Flu	☐ YES ☐ NO	_____
Pneumonia-23	☐ YES ☐ NO	_____
Prevnar-13	☐ YES ☐ NO	_____
Tetanus	☐ YES ☐ NO	_____
Pertussis	☐ YES ☐ NO	_____
HPV/Gardasil	☐ YES ☐ NO	_____
Hepatitis A	☐ YES ☐ NO	_____
Hepatitis B	☐ YES ☐ NO	_____
Meningitis	☐ YES ☐ NO	_____
Shingles	☐ YES ☐ NO	_____

Patient Signature: _____ Date: _____

Healthcare Provider Signature: _____ Date: _____

Patient Name: _____ Date of Birth: ___ / ___ / ___

(Last) (First) (Middle)

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 ☐ None ☐ Blood in Urine ☐ Erectile Dysfunction ☐ Vaginal Discharge ☐ Breast Lump or Pain ☐
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: _____