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: _____