

Please list the medications you are currently taking. Please include all over-the-counter and herbal medications (use back of page if needed):

Medication Name	Dosage	How often	Started	Problem medication for	Doctor who wrote

Pharmacy Name and Address _____

Do you get your medications for 30 days or 90 days at a time? (circle one) **30 days** **90 days**

Please list any drug allergies or side effects (use back page if needed)

When	Drug	Describe Reaction

Immunizations (list date of last)

Tetanus	Pneumonia	Shingles	Flu

List all the physicians that you are currently seeing:

Physician Name	Specialty	Condition being treated	Next Office Visit	Would you like a copy of your visit sent to this doctor?

Review of Systems- MEN ONLY

Please check a box below for every question that applies to your current health

General

	No	Yes
Chills		
Fatigue		
Fever		
Night sweats		
Tired		
Weight gain		
Weight loss		
Other:	_____	

Urinary

	No	Yes
Dribbling		
Painful urination		
Blood in urine		
Excessive urination		
Slow stream		
Increased frequency		
Unable to hold urine		
Trouble emptying bladder		
Other:	_____	

Skin

	No	Yes
Brittle hair		
Brittle nails		
Hair loss		
Excessive hair growth		
Hives		
Itching		
Mole changes		
Rash		
Skin lesion		
Other:	_____	

Head/Neck

	No	Yes
Ear drainage		
Ear pain		
Eye discharge		
Eye pain		
Hearing loss		
Nasal drainage		
Sinus pressure		
Sore throat		
Visual changes		
Other:	_____	

Reproductive

	No	Yes
Erection problems		
Discharge from penis		
Decreased libido		
Other:	_____	

Musculoskeletal

	No	Yes
Back pain		
Joint pain		
Joint swelling		
Muscle weakness		
Neck pain		
Other:	_____	

Metabolic

	No	Yes
Cold intolerance		
Heat intolerance		
Always thirsty		
Always hungry		
Other:	_____	

Blood/Lymph

	No	Yes
Easy bleeding		
Easy bruising		
Enlarged lymph nodes		
Other:	_____	

Respiratory

	No	Yes
Chronic cough		
Recent cough		
Known TB exposure		
Shortness of breath		
Wheezing		
Other:	_____	

Neurological

	No	Yes
Dizziness		
Numbness in arms/legs		
Weakness in arms/legs		
Trouble walking		
Headache		
Memory loss		
Seizures		
Tremors		
Other:	_____	

Immunity

	No	Yes
Contact allergy		
Environmental allergy		
Food allergy		
Seasonal allergy		
Other:	_____	

Heart

	No	Yes
Chest pains		
Leg pain with walking		
Swelling in legs		
Heart racing		
Other:	_____	

Psychiatric

	No	Yes
Anxiety		
Depression		
Trouble sleeping		
Other:	_____	

Gastrointestinal

	No	Yes
Abdominal pain		
Blood in stools		
Change in stools		
Constipation		
Diarrhea		
Heartburn		
Loss of appetite		
Nausea		
Vomiting		
Other:	_____	

Review of Systems- WOMEN ONLY

Please check a box below for every question that applies to your current health

General

	No	Yes
Chills		
Fatigue		
Fever		
Night sweats		
Tired		
Weight gain		
Weight loss		
Other:	_____	

Urinary

	No	Yes
Painful urination		
Blood in urine		
Excessive urination		
Increased frequency		
Unable to hold urine		
Trouble emptying bladder		
Other:	_____	

Psychiatric

	No	Yes
Anxiety		
Depression		
Trouble sleeping		
Other:	_____	

Metabolic

	No	Yes
Cold intolerance		
Heat intolerance		
Always thirsty		
Always hungry		
Other:	_____	

Head/Neck

	No	Yes
Ear drainage		
Ear pain		
Eye discharge		
Eye pain		
Hearing loss		
Nasal drainage		
Sinus pressure		
Sore throat		
Visual changes		
Other:	_____	

Reproductive

	No	Yes
Abnormal pap smear		
Painful periods		
Painful intercourse		
Hot flashes		
Irregular periods		
Vaginal discharge		
Other:	_____	

Musculoskeletal

	No	Yes
Back pain		
Joint pain		
Joint swelling		
Muscle weakness		
Neck pain		
Other:	_____	

Respiratory

	No	Yes
Chronic cough		
Recent cough		
Known TB exposure		
Shortness of breath		
Wheezing		
Other:	_____	

Skin

	No	Yes
Brittle hair		
Brittle nails		
Hair loss		
Excessive hair growth		
Hives		
Itching		
Mole changes		
Rash		
Skin lesion		
Other:	_____	

Blood/lymph

	No	Yes
Easy bleeding		
Easy bruising		
Enlarged lymph nodes		
Other:	_____	

Heart

	No	Yes
Chest pains		
Leg pain with walking		
Swelling in legs		
Heart racing		
Other:	_____	

Neurological

	No	Yes
Dizziness		
Numbness in arms/legs		
Weakness in arms/legs		
Trouble walking		
Headache		
Memory loss		
Seizures		
Tremors		
Other:	_____	

Immunity

	No	Yes
Contact allergy		
Environmental allergy		
Food allergy		
Seasonal allergy		
Other:	_____	

Gastrointestinal

	No	Yes
Abdominal pain		
Blood in stools		
Change in stools		
Constipation		
Diarrhea		
Heartburn		
Loss of appetite		
Nausea		
Vomiting		
Other:	_____	

Past Medical History

Place check all that apply to you

Allergies	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Cancer (type)	<input type="checkbox"/>	Heartburn/ reflux	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>
Chest pains	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Headache, Migraine	<input type="checkbox"/>	Seizure	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Heart valve disorder	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Depression	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>		
Atrial fibrillation	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Irritable bowel disease	<input type="checkbox"/>		
Enlarged prostate	<input type="checkbox"/>	Elevated Lipids	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>		

Past Surgical History

Place the Year (if known) to all that apply to you

	Year		Year	Men Only	Year	Women Only	Year
Heart Balloon	<input type="checkbox"/>	Colostomy Bag	<input type="checkbox"/>	Prostate Biopsy	<input type="checkbox"/>	Breast Implants	<input type="checkbox"/>
Heart Stent	<input type="checkbox"/>	Gastric Bypass	<input type="checkbox"/>	Prostate Surgery	<input type="checkbox"/>	Tubal	<input type="checkbox"/>
Appendix Removal	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	Vasectomy	<input type="checkbox"/>	Breast Biopsy	<input type="checkbox"/>
Back Surgery	<input type="checkbox"/>	Hip Replacement	<input type="checkbox"/>			C-section	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	Knee Replaced	<input type="checkbox"/>			D&C	<input type="checkbox"/>
Heart Bypass	<input type="checkbox"/>	LASIK Eye	<input type="checkbox"/>			Hysterectomy	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	ORIF	<input type="checkbox"/>			Mastectomy	<input type="checkbox"/>
Carpal Tunnel	<input type="checkbox"/>	Thyroid Removal	<input type="checkbox"/>			Fibroid Removal	<input type="checkbox"/>
Cataract Removal	<input type="checkbox"/>	Tonsil Removal	<input type="checkbox"/>			Breast Reduction	<input type="checkbox"/>
Gallbladder Removal	<input type="checkbox"/>					Hyst and Ovaries	<input type="checkbox"/>
Intestine Removal	<input type="checkbox"/>					Vaginal Hyst	<input type="checkbox"/>

Other: _____

Past Diagnostic Studies

Last Colonoscopy: Date _____ Result _____

Last Bone Density Date: _____ Result _____

Please list any MRI's, CT's, Ultrasounds or X-Ray's. Include the body area imaged and date:

Family History

Place a check mark in the box to all that apply

___ Adopted/unknown

	Mother	Father	Sister	Brother	Other
Alive (age)					
Deceased (at what age)					
Attention Deficit Disorder					
Alcoholism					
Allergies					
Alzheimer's disease					
Arthritis					
Asthma					
Blood disease					
Cancer					
Type of cancer					
Heart disease after 50					
Heart disease before 50					
Depression					
Developmental Problems					
Diabetes					
Skin problems					
Elevated Lipids					
Genetic disease					
Hearing problems					
High blood pressure					
Irritable bowel disease					
Learning problems					
Mental illness					
Migraines					
Obesity					
Osteoporosis					
Poor circulation					
Kidney disease					
Seizures					
Stroke					
Thyroid disorder					

Other relevant family history:

Social History

Tobacco History:

Smoking Tobacco Use

Tobacco Type:	Use daily	Usage per day	Years used	Age started	Age stopped
<input type="checkbox"/> Cigarette	<input type="checkbox"/>	___ #packs/cig	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Cigarillo	<input type="checkbox"/>	___ cigarillos	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Cigar	<input type="checkbox"/>	___ cigars	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Pipe	<input type="checkbox"/>	___ pipes	<input type="text"/>	<input type="text"/>	<input type="text"/>

Non-Smoking Tobacco Use

Tobacco Type:	Use Daily	Usage per day	Years used	Age started	Age stopped
<input type="checkbox"/> Chewing	<input type="checkbox"/>	___ units	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Smokeless	<input type="checkbox"/>	___ units	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Snuff	<input type="checkbox"/>	___ units	<input type="text"/>	<input type="text"/>	<input type="text"/>

Have you ever tried to quit smoking? No / Yes

Year quit? _____

Cessation method? _____ Longest period tobacco free? _____

Relapsed? Yes / No

If so, why?

Alcohol History:

No ___ Yes ___ Formerly (list year quit) _____

Type of alcohol _____

How frequently _____

How much a day? _____

When was your last drink? _____

Caffeine History:

Yes ___ No ___ if Yes Type? _____ Servings Per Day _____

Demographics:

The Federal Government requires us to collect the following information.

This information is part of the medical record and is subject to privacy laws.

Race (must choose one):

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Other: _____

Ethnicity (check one) ___ Hispanic ___ Non-Hispanic

Primary Language Spoken: _____

Country of Birth (if not US): _____

Hand Dominance: ___ Right ___ Left ___ Ambidextrous

Education:

Highest level of Education: _____

Any Degree obtained: _____

Employment:

Employer: _____

Occupation: _____

Employment Status: _____

If Retired, Date: _____

Military Experience:

No _____ Yes _____

Branch: _____

Years served: _____

Domestic:

Current Marital Status (circle one): Single Married Widowed Divorced

Previously widowed? No Yes

Previously divorced? No Yes

Children? No Yes

Sons _____

Daughters _____

Who lives with you? _____

Sleep Patterns:

Changes in sleep patterns: No Yes

Average number of hours of sleep per night: _____

Trouble falling asleep: No Yes

Difficulty staying asleep: No Yes

Frequent waking episodes at night: No Yes

Disrupted breathing, gasping, gagging or choking for air during sleep: No Yes

Lifestyle:

Activity level: Moderate Sedentary Vigorous

Health club member: Now Previously Never

Type of exercise: _____

Exercise frequency: _____

Hours/week: _____

Hobbies/Activities: _____

Current Diet : _____

Animals in the home: No Yes Type _____

Religious/Spiritual:

Do you have a religious affiliation? No Yes

Religion name: _____

Home Environment/Safety:

Smoke detectors in home? No Yes

Carbon monoxide detectors in home? No Yes

Falls in the last year? No Yes

Number of falls: _____

Pool/spa at home: No Yes

Seat belt use? No Yes

Recent Travel

Out of state? _____

Out of country? _____

Known exposure to disease? _____