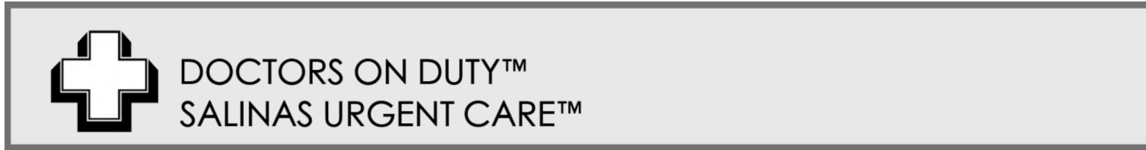
Patient Name: ______________________________ DOB: ________________



Patient Name: ______________________________ DOB: ________________

Your answers on this form will help your clinician understand your medical concerns and conditions better. Best estimates are fine if you cannot remember specific details.

REASON FOR VISIT: ____

____

IMMUNIZATIONS:
When was your most recent Tetanus immunization? ____________
When was your most recent Influenza immunization? ____________
When was your most recent pneumococcal immunization? ____________
Are you up to date on all immunizations? ☐ Yes ☐ No

WOMEN'S GYNECOLOGIC HISTORY:
1st day of your most recent period: ________________________
Is there a possibility you may be pregnant? ☐ Yes ☐ No

ALLERGIES or REACTIONS TO MEDICATIONS/FOODS/OTHER AGENTS:

Allergic to:	Reaction or Side Effect

☐ No Known Drug Allergies

MEDICATIONS: Prescription and non-prescription medicines, vitamins, and birth control pills:

Medication	Dose	Times per day

☐ Not currently taking medications

PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the following medical problems:

☐ Alcoholism
☐ Abnormal Pap smear
☐ Blood disorder
☐ Cancer (Malignancy)
☐ Congenital Heart disease
☐ Depression/Anxiety
☐ Diabetes: *type I (requires insulin)*
☐ Diabetes: *type II*
☐ High cholesterol
☐ Hypertension (High blood pressure)
☐ Myocardial Infarction (Heart attack)
☐ Stroke
☐ Thyroid problem
☐ Other: ____________________

Patient Name: ______________________________ DOB: ________________

SURGICAL HISTORY (Please list all prior operations and dates)**:**

Operation	Date

FAMILY HISTORY

List any of your family members (father, mother, brother, and sister) that have had any of the following illnesses:

Disease Name	Father	Mother	Brother	Sister
Alcoholism				
Alzheimer's				
Arthritis				
Asthma				
Cancer				
COPD				
Depression				
Diabetes				
Heart Attack				
Heart Disease				
High Cholesterol				
Hypertension				
Hypothyroidism				
Other:				

SOCIAL HISTORY

Tobacco Use	Alcohol Use	
Cigarettes Current: Smoker: ☐ Yes ☐ No ☐ Never ☐ Quit: Date__________ packs/day____ # of yrs ________ **Other Tobacco:** ☐ Cigar ☐ Chew ☐ Pipe ☐ Snuff Are you interested in quitting? ☐ Yes ☐ No **Second Hand Smoke:** Smoke exposure in the home? ☐ Yes ☐ No	Do you drink alcohol? ☐ Yes ☐ No, # drinks/week _______	Is alcohol use a concern for you or others? ☐ Yes ☐ No
	Drug Use	
	Do you use any recreational drugs? ☐ Yes ☐ No If yes, indicate what type ____________________ Have you ever used needles? ☐ Yes ☐ No	

Patient Name: ______________________________ DOB: ________________

REVIEW OF SYMPTOMS you are experiencing today: Please indicate either negative or positive by placing a check (√) in the boxes provided.

NEG/POS **Constitutional**
- ☐ ☐ Recent fever
- ☐ ☐ Recent chills
- ☐ ☐ Unexplained fatigue/weakness

NEG/POS **Eyes**
- ☐ ☐ Blurred vision
- ☐ ☐ Eye pain
- ☐ ☐ Eye drainage

NEG/POS **Ears/Nose/Throat/Mouth**
- ☐ ☐ Difficulty hearing
- ☐ ☐ Continuous post nasal drip
- ☐ ☐ Hoarseness of voice change
- ☐ ☐ Sore Throat
- ☐ ☐ Ear Pain

NEG/POS **Cardiovascular**
- ☐ ☐ Chest pains/discomfort
- ☐ ☐ Palpitations

NEG/POS **Respiratory**
- ☐ ☐ Chronic Cough
- ☐ ☐ Wheezing
- ☐ ☐ Acute Cough
- ☐ ☐ Shortness of breath

NEG/POS **Gastrointestinal**
- ☐ ☐ Heartburn
- ☐ ☐ Acid reflux
- ☐ ☐ Nausea/vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Abdominal pain

NEG/POS **Genitourinary**
- ☐ ☐ Painful urination
- ☐ ☐ Nighttime urination
- ☐ ☐ Frequent urination
- ☐ ☐ Discharge: Penis or Vagina

NEG/POS **Musculoskeletal**
- ☐ ☐ Muscle pain
- ☐ ☐ Joint pain
- ☐ ☐ Joint stiffness
- ☐ ☐ Recent back pain

NEG/POS **Skin**
- ☐ ☐ Rashes or Itching
- ☐ ☐ Fungal nail infection
- ☐ ☐ Warts
- ☐ ☐ Dry Skin

NEG/POS **Neurological**
- ☐ ☐ Headaches
- ☐ ☐ Memory loss
- ☐ ☐ Fainting
- ☐ ☐ Dizziness
- ☐ ☐ Numbness

NEG/POS **Blood/Lymphatic**
- ☐ ☐ Unexplained lumps/nodes
- ☐ ☐ Excessive bleeding
- ☐ ☐ Easy bruising

NEG/POS **Endocrinology**
- ☐ ☐ Excessive sweating
- ☐ ☐ Thyroid trouble
- ☐ ☐ Cold/heat intolerance
- ☐ ☐ Increase thirst/appetite

NEG/POS **Allergy/Immunologic**
- ☐ ☐ Seasonal Allergies
- ☐ ☐ Altered Immune System

NEG/POS **Psychiatric**
- ☐ ☐ Anxiety/stress
- ☐ ☐ Sleep problems
- ☐ ☐ Nervousness/Depression

PHARMACY:
Pharmacy for today's medications?____

Patient/Guardian Signature:______________________________ Date: ____________