



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Past Medical History: Please circle conditions that you have now or have had in the past.**

High Blood Pressure	Macular Degeneration	Kidney Stones	MRSA infection
High Cholesterol	Asthma	Urinary tract Infection	Hepatitis
Heart Disease	Pneumonia	Kidney Disease	Kidney Disease
Heart Attack	Emphysema	Arthritis	Sickle Cell
Congestive Heart Failure	COPD	Lupus	Irregular Heartbeat
Blood Clot	Tuberculosis (TB)	Gout	Atrial Fibrillation
Stroke	Acid Reflux/ GERD	Psoriasis	Dementia
TIA (mini-stroke)	Stomach Ulcers	Osteoporosis	Hearing Loss
Seizures	Gallstones	Thyroid Disorder (High/Low)	Allergies
Headaches	Liver Disease	Anemia	Memory Loss
Migraine Headaches	Diverticulitis	Bleeding Disorder	Seizures
Diabetes	Hemorrhoids	Neck Disorder	Depression
Anxiety	Colon Polyps	Back Disorder	Alcoholism
Glaucoma	Enlarged Prostate	Cancer Type:	Anorexia/Bulimia
Cataracts	Polycystic Ovaries	HIV/ AIDS	Herpes/Shingles
<b>Other Medical Conditions:</b>			
<b>Medication and Food Allergies:</b>		<b>Reaction:</b>	

**Medications: Please list all prescription and over the counter medications you are taking.**

Medication Name	Dose	How often?	How Long?



**Health Screening: Please mark if you have had the following tests and the date performed.**

Screening Test	Yes/No	Date/Results	Screening Test	Yes/No	Date/Results
Cholesterol			Colonoscopy		
Blood Pressure			Chest X-Ray		
Blood Sugar			Mammogram		
EKG			Pap Smear		
Skin Check			Prostate Exam		
Spirometry			Oxygen level		
Dexa Bone Scan			Sleep Study		

**Review of systems: Please circle any symptoms you have experienced recently.**

General	Ears	Eyes	Nose	Throat
Weight Gain	Hearing loss	Vision loss	Nosebleed	Hoarseness
Weight Loss	Ringing in ears	Blurry Vision	Nasal congestion	Sore throat
Loss of appetite	Wax problems	Redness	Sinus pain	Itchy throat
Night Sweats	Ear pain	Drainage	Post nasal drip	Difficulty swallowing
Weakness	Ear drainage	Dry Eyes	Snoring	Painful swallowing
Fatigue		Itchy eyes	Decreased smell	
Swollen Glands				
Cardiovascular	Respiratory/Chest	Gastrointestinal	Urinary	Allergy
Chest Pain	Cough	Nausea/Vomiting	Painful urination	Sinus Pain
Chest Pressure	Shortness of breath	Stomach Pain	Flank Pain	Sinus Congestion
Irregular heartbeat	Wheezing	Heartburn	Nighttime urination	Hives
Fast heart beat	Coughing up blood	Diarrhea	Urine leakage	Itchy eyes
Swollen legs/ankles	Breast Lump	Constipation	Difficulty urinating	Runny Nose
Varicose veins	Nipple Discharge	Bloody stool	Frequent urination	
Easy bruising		Mucous in stool	Blood in urine	
		Rectal bleeding	Urinary tract infection	
Neurology	Skin	Musculoskeletal	Psychiatric	Medical Equipment
Headache	Rash	Joint Pain	Difficulty sleeping	Nighttime oxygen
Numbness/Tingling	Itchy Skin	Joint Swelling	Stress	Daytime oxygen
Memory Difficulties	Dry Skin	Joint Redness	Low energy level	CPAP
Speech Problems	New Mole	Joint Stiffness	Anxiety	BIPAP
Tremors	Change in Mole	Muscle Pain	Change in Mood	Walker
Loss of Balance	Skin tags	Back Pain	Change in Behavior	Cane
Dizzy/vertigo	Hair loss	Neck Pain	Suicidal thoughts	Insulin Pump
Fainting	Heat intolerance	Loss of strength	Eating Disorder	Pacemaker
Fall	Cold intolerance		Domestic Abuse	Hearing aid(s)
	Sores that won't heal			Glasses/contacts
For Female Patients			For Male Patients	
Age of First Period _____ Date of Last Period _____ Age of Menopause _____ Bleeding Between Periods _____ Number of Pregnancies _____ Number of Children _____ Have you had Hysterectomy? _____ Ovaries removed? _____			Erection Difficulties: Yes/NO Lump In Testicles: Yes/NO Other:	



**Surgeries and Hospitalizations: Please list date, Hospital and Reason:**


**Social History:**

<b>Tobacco Use:</b>	Yes/ No	Date Quit	Type:	Amount per Day:
<b>Exposure to Second hand smoke:</b>	Yes/No	How Long:	Type:	
<b>Alcohol/Type:</b>	Yes/No	Date Quit	Type:	How Often:
<b>Recreational Drugs/Type:</b>	Yes/No	Date Quit	Type:	How Often:
<b>Caffeine</b>	Yes/No	Date Quit	Type:	Amount per Day:
<b>Do you live alone</b>	Yes/No	Who Do you live with?		
<b>Do you use Home Health Care?</b>	Yes/ No	Company Name:		Reason:
<b>Do you live in a nursing home or Assisted living Facility?</b>	Yes/ No	Facility Name:		
<b>Do you Have any Home Health Care needs?</b>	Yes/ No	What can we assist you with?		
<b>Do you Have any Hospice or Palliative care needs?</b>	Yes/ No	What can we assist you with?		

**Specialists:**

<b>Specialty</b>	<b>Physician's name</b>	<b>Specialty</b>	<b>Physician's name</b>
<b>Cardiology (Heart)</b>		<b>Nephrology (kidney)</b>	
<b>Pulmonology (Lungs)</b>		<b>Neurology (Brain)</b>	
<b>Gastroenterology (stomach)</b>		<b>Gynecology (women's)</b>	
<b>Dermatology (Skin)</b>		<b>Urology (Bladder)</b>	
<b>Oncology (Cancer)</b>		<b>Infectious Disease</b>	
<b>Hemotology (Blood)</b>		<b>Psychology (Mind)</b>	
<b>Surgery</b>		<b>Podiatry (Foot)</b>	



Family Medical History: Please circle if any relatives have the following and write & how they are related.

Heart Attack		Breast Cancer	
High Cholesterol		Colon Cancer/Polyps	
High Blood Pressure		Prostate Cancer	
Diabetes		Ovarian Cancer	
Stroke		Blood Clots	
Other:		Other:	

**Immunization History:**

Immunization Name	Have you been Immunized?	Date/Year
Seasonal Influenza (Flu Shot)	Y/N	
H1N1 Influenza	Y/N	
Tetanus	Y/N	
Pneumococcal (pneumonia shot)	Y/N	
Hepatitis B series	Y/N	
Chicken Pox	Y/N	
Other:		

**Pharmacy:**

Local Pharmacy Name:	Phone #:	City:
Mail Order Pharmacy Name:	Phone #:	
Member ID #		

Please mark how we may contact you:

Can we call you at this number?      Can we leave a message?

Home Phone:	Y/N	Y/N
Cell Phone:	Y/N	Y/N
Work Phone:	Y/N	Y/N
Email:	Y/N	Y/N

Any other information or needs you would like your physician to know:


