

Patient name: _____

DOB: _____

Date: _____

Current Medications

Please list all medications you are taking at this time, include vitamins, topicals, injections, supplements & herbal or provide a complete list (use back if needed)

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Why do you take this medication?
1			
2			
3			
4			
5			
6			
7			
8			

PHARMACY _____ **(for local prescriptions)**

Allergies-*Please list all medications and environmental agents you are allergic to. Please include what type of reaction you have (hives, nausea, breathing problems, etc.) and severity.*

Past Medical History- *Please include all medical problems such as diabetes, hypertension, etc.*

Past Surgical History- *Please list all procedures including surgeries, colonoscopies, heart catheterizations, etc. and year performed.*

PRIMARY CARE PHYSICIAN _____ **address** _____

Phone number _____

Patient name: _____

DOB: _____

Date: _____

Family Medical History: unknown ____ adopted ____

Mother Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Father Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Sister Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Brother Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Maternal Grandmother Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Maternal Grandfather Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Paternal Grandmother Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Paternal Grandfather Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Maternal Aunts/uncles Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

Paternal Aunts/uncles Cancer: type _____ stroke heart disease diabetes
Other _____ dementia blood/genetic disorder

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Social History

SMOKING/NICOTINE

Do you currently smoke? Yes/No

If Yes: how many years _____

how many cigarettes/packs per day _____

Have you ever smoked? Yes/No

If Yes: When did you quit _____

Do you currently use any other nicotine products such as patches or gum? Yes/No

Have you ever or do you currently use any type of smokeless tobacco? Yes/No if yes, what type _____

Do you vape or use e cigarettes? Yes/no/never/not currently-

ALCOHOL

Do you ever drink alcohol? Yes/No

If Yes: how many drinks/month _____

SUBSTANCE USE

Do you use illegal substances? CIRCLE--- In the past/ currently/ never

What type _____ & How often _____

If in the past When did you quit _____

SEXUAL ACTIVITY:

Are you sexually active: Yes/No Male/female partner Women: first day of last period _____

If sexually active could you be pregnant and what birth control method do you use? _____

SOCIOECONOMIC

Are you employed? Yes/No

If Yes: What type of work do you do or title _____

DEMOGRAPHICS

Marital status

Are you: Single Married Legally Separated Divorced Widowed Significant other

Spouse/Significant other's Name _____

Number of living Biologic Children _____ number of living step Children _____ number of adopted children _____

SOCIAL DOCUMENTATION

Do you participate in any physical activity ? Yes/No

If Yes, what and how often _____

Do you care for any large animals (over 40 pounds)? Yes/no type _____

Do you have to help care for disabled dependents or family members? Yes/no

If Yes does the care involve physical lifting Yes/no

Obstetric history-*females only*

Number of pregnancies ____

Number of vaginal deliveries ____

Number of cesarean sections ____

Number of abortions ____

Number of ectopic pregnancies ____ Number of miscarriages ____

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Review of Systems (symptoms within the last 7 days)

Constitution

Fatigue YES NO
Fever YES NO
Unexpected Weight Change YES NO
Other _____ YES NO

Ear/Nose/Throat

Congestion YES NO
Hearing Loss YES NO
Nosebleeds YES NO
Sinus Pain YES NO
Sore Throat YES NO

Eyes

Visual Disturbance YES NO

Respiratory

Stop breathing YES NO
Cough YES NO
Shortness of breath YES NO
Wheezing YES NO
Other _____ YES NO

Cardiovascular

Chest Pain YES NO
Leg Swelling YES NO
Palpitations YES NO
Other _____ YES NO

Gastroenterology

Abdominal Pain YES NO
Constipation YES NO
Nausea YES NO
Vomiting YES NO
Other _____ YES NO

Musculoskeletal

Joint Pain YES NO
Back Pain YES NO
Difficulty Walking YES NO
Joint Swelling YES NO
Muscle Pain YES NO

Skin

Color Change YES NO
Rash YES NO
Wound YES NO

Immunosuppressed

Immunocompromised YES NO
Other _____ YES NO

Neurological

Dizziness YES NO
Facial Asymmetry YES NO
Headaches YES NO
Light Headedness YES NO
Numbness YES NO
Seizure YES NO
Fainting YES NO
Weakness YES NO

Hematologic

Bruises easily YES NO
Other _____ YES NO

Psychiatric

Confusion YES NO
Dysphoric Mood YES NO
Nervous/Anxiety YES NO
Suicidal Ideas YES NO

Endocrine

Cold Intolerance YES NO
Heat Intolerance YES NO
Other _____ YES NO

Urinary/Reproductive

Difficulty Urinating YES NO
Painful Urination YES NO
Frequent Urination YES NO
Blood in Urine YES NO
Urgency YES NO

Female

Vaginal Bleeding YES NO
Vaginal Discharge YES NO