| **Full Name:** | **Date of Birth:** **Sex:** |
|---|---|
| **Address:** | **Email Address:** |
| **City, State, Zip:** | **Cell Phone (if available):** |

## Allergy

List allergies to medications as well as the reaction that you had when you took it. If your parents told you that you were allergic to it, just write "parents."
If you have no allergies that you know of, check here: ☐

| Medication | Type of Allergic Reaction |
|---|---|
| | |
| | |
| | |

## Immunizations

Parents: If this form is for a child, please bring a copy of the immunizations to the office so we can record them in the medical record.

| Immunization | Approx Date |
|---|---|
| Last Tetanus | |
| Hepatitis | |
| Pneumococcal | |
| Flu Vaccine | |

| Other Immunizations | Approx Date |
|---|---|
| | |
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## Family Medical History

If you are adopted, check here ☐
**Fill out what is known about your family history with regard to the following conditions/diseases/afflictions:**

| *Consider the following:* | Relative | Major Illnesses or Cause of Death | Living/ Deceased | Age |
|---|---|---|---|---|
| **Heart** | Father | | | |
| **Lung** | Mother | | | |
| **Kidney** | Brothers/Sisters | | | |
| **Blood/Bleed** | | | | |
| **Tumors/Cancer** | | | | |
| **Diabetes** | | | | |
| **Bowel/Intestinal** | | | | |
| **Endocrine** | | | | |
| **Thyroid** | Daughters/Sons | | | |
| **Hypertension** | | | | |
| **Mental Illness** | | | | |
| **Alcoholism** | | | | |
| **Suicide** | | | | |
| **Any other** | | | | |
| | | | | |



**Patients: →Please initial here:**_____

## Current Medical Problems

Please list those problems that require ongoing treatment or consideration. If none, check here: ☐

| **Diabetes, heart disease, angina, high blood pressure, emphysema or other lung disease, treatment for cancer, paralysis, effects of stroke, vision or hearing impairment, or any other incapacitation.** | |
|---|---|
| **Disease or Incapacitation** | **Approx Date of Onset** |
| | |
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## Previous Hospitalizations

List all hospitalizations (as many as you can remember) including surgeries, childbirth, injuries, heart attacks, pneumonia, or any other medical or surgical reason you have been admitted to the hospital.

| **Date** | **Reason for Hospitalization** |
|---|---|
| | |
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## Health Maintenance

Have you had any of the following and what are the dates?

| Evaluation | Approx Date | | Evaluation | Approx Date |
|---|---|---|---|---|
| Last Annual Exam | | | Blood test for Lipid/Cholesterol | |
| Mammogram | | | PSA | |
| Pap Smear | | | Stools for hemoccult blood | |
| Digital Rectal Exam *(DRE)* | | | Dexa Scan *(for osteoporosis)* | |
| Colonoscopy | | | Cardiovascular or Stress Test | |
| Eye Exam | | | Colposcopy | |
| Hearing Test | | | Electrocardiogram (EKG) | |
| Foot Exam | | | **Other tests:** | |



**Patients: →Please initial here:**_____

## Social History

Do you **smoke**?___ →If so, how much and when did you start?_____

Do you use **alcohol**?___ →If so, how many drinks per day or week?_____

How much **caffeine** do you drink in a day (coffee, tea, soda)?_____

Do you use any other **drugs**?___ → If so, what kind, and how often?_____

What **work** or employment do you do *(or retired from)*?_____

What **exercise**, if any, do you do and how often?_____

Do you wear your **seatbelt**?___ → If so, how often? ☐ ALWAYS ☐ SOMETIMES ☐ NEVER

Have you ever had a **blood transfusion**?___ → How many units and what years?_____

Have you **traveled** out of the United States in the past year?___ If so, where?_____

Are you **sexually active**?_____ → What form, if any, of birth control are you using?_____

## Current Medications

List only those medications that you take on a regular basis. Include any over-the-counter, herbal or supplemental medications that you take

| Medication | Strength | Number of Doses per Day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
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## For Women

Last normal menstrual period:_____ HEAVY REGULAR LIGHT SPOTTING

How many days from the start of one period to the start of the next?_____

Total number of times pregnant:_____ Number of births:_____ Twins:_____

Number of miscarriages or lost pregnancies:_____ How many living children:_____

If you no longer have periods, why not?

☐Hormone treatment ☐Hysterectomy ☐Menopausal ☐No known reason ☐Never had periods



**Patients: →Please initial here:**_____

## Review of Systems

**Circle** any of the following that apply or that you would like to discuss with your provider.

**General**
- Any significant weight change

**Skin**
- New lesions or sores
- Change in a mole or wart

**HEENT**
- Regular or severe headaches
- Pain in or around the eye
- Dizziness (room seems to spin)
- Change in voice
- Blurred or change in vision
- Seasonal allergies/runny nose
- Double vision
- Hearing impairment or change

**Neck**
- Swelling or mass in neck
- Neck pain

**Respiratory**
- Chronic dry cough
- Decrease in exercise tolerance
- Coughing up blood
- Constant productive cough
- Short of breath/difficulty breathing

**Cardiovascular**
- Chest pain at rest or w/ exercise
- Swelling of the feet/ankles
- Can't breath when laying down
- Short of breath more than usual
- Can't breath when walking
- Can't breath when going up stairs

**Gastrointestinal**
- Swelling or mass in abdomen
- Pain in abdomen
- Chronic constipation
- Chronic diarrhea
- Can't tolerate certain foods
- Notice blood on the toilet paper
- Stools have blood in them
- Experiencing heart burn
- Vomiting blood
- Noticed a black, tarry stool

**Musculoskeletal**
- Joint pain
- Chronic back pain

**Neurological**
- Constant or recurrent headaches
- Difficulty with coordination/walking
- Dizziness (feels like I'm moving)
- Weakness / Fatigue
- Feels like passing out
- Changed/decreased vision

**Psychiatric**
- Chronic or recurrent Anxiety
- Difficulty sleeping
- Depression longer than a week
- Recurrent suicidal thoughts
- Can't get to sleep
- Wake up / can't get back to sleep

**Endocrine**
- Intolerant to cold
- Intolerant to heat
- Noticed changes in my hair
- Hair falling out
- Having problems sexually
- Always thirsty and drink a lot
- Have to urinate all the time

**Hematology**
- Noticed more easily bruised

**Genitourinary**
- Hurts to urinate
- Have trouble starting my stream
- Can't hold my urine sometimes
- Urinating all the time in large amts
- Noticed blood in my urine

**For Males:**
- Have trouble with erections
- Noticed mass in penis or testicle
- Have sexual problem to discuss

**For Females:**
- Abnormal vaginal bleeding
- Intercourse is painful
- Noticed a mass in by breast
- Breasts are painful
- Noticed a nipples discharge

Other concerns I wish to discuss:



**Patients: →Please initial here:**_____