

Welcome to our practice! Please complete both sides of this form. Thank you

NAME: _____ Age: _____ Referring MD/ARNP: _____

Reason for visit? _____

PAST MEDICAL HISTORY: please check problems which you had in the past or currently have

Mumps or measles	kidney stones	High cholesterol
Chicken pox	peptic ulcer disease	poor circulation
Tuberculosis HIV /AIDS	osteoporosis	congestive heart failure
neck radiation	Hiatal Hernia	stroke or TIA
Blood clots	Asthma	Heart disease
Cancer yes no Type:	Migraines	Hypertension
Vasectomy	Gestational Diabetes	Carotid artery disease

Please list any other medical problems not mentioned above.

PAST SURGERIES: please check and list your surgeries. Include dates if known.

gallbladder appendix hysterectomy

MEDICATIONS: (please include any non-prescription drugs or herbals)

ALLERGIES: (please list any food or drug allergies)

FAMILY HISTORY: please give us the medical problems of your family members

Father _____ Mother _____

Sisters _____ Brothers _____

Children _____ Other _____

TOBACCO: please place check mark where appropriate

Do you smoke tobacco? never yes Quit When? _____

ALCOHOL: please place check mark where appropriate

How much alcohol do you drink? none socially moderate daily

SOCIAL HISTORY: please place check mark where appropriate

Marital status: single married separated divorced widowed

Name of Employer: _____ Position: _____

Please complete page 2 of this form. Thank you!

INTERVENTIONS: Please check if you had any of the following?

Flu vaccine last year pneumonia vaccine Hepatitis vaccine

Please check and give us the name of any of the following specialists you saw within the past year.

Heart doc Dr. _____ Foot doc Dr. _____
 Eye doc Dr. _____ Kidney doc Dr. _____

If you have diabetes, how many times a day do you test your blood sugar? 0 1 2 3 _____

Year diagnosed: _____ Name of your glucose meter: _____

EXERCISE: Yes No Type: _____ Physical Activity Type: _____

COMPREHENSIVE REVIEW OF SYSTEMS: please check off all current symptoms

CONST: <input type="checkbox"/> fever <input type="checkbox"/> night sweats <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss <input type="checkbox"/> exercise intolerance
EYES: <input type="checkbox"/> dry eyes <input type="checkbox"/> irritation <input type="checkbox"/> vision change <input type="checkbox"/> legally blind
ENMT: <input type="checkbox"/> difficulty hearing <input type="checkbox"/> ear pain <input type="checkbox"/> frequent nosebleeds <input type="checkbox"/> sinus problems <input type="checkbox"/> sore throat <input type="checkbox"/> teeth problems <input type="checkbox"/> dentures <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> mouth ulcers <input type="checkbox"/> neck pain <input type="checkbox"/> neck swelling <input type="checkbox"/> hoarseness
HEART/CV: <input type="checkbox"/> chest pain at rest <input type="checkbox"/> chest pain on exertion <input type="checkbox"/> heart beating fast (palpitations) <input type="checkbox"/> heart murmur <input type="checkbox"/> shortness of breath when walking <input type="checkbox"/> shortness of breath when lying down <input type="checkbox"/> light-headed on standing
RESP: <input type="checkbox"/> persistent cough <input type="checkbox"/> wheezing <input type="checkbox"/> coughing up blood <input type="checkbox"/> sleep apnea
GI: <input type="checkbox"/> abdominal (stomach) pain <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> decreased appetite <input type="checkbox"/> increased appetite
GU: <input type="checkbox"/> breast discharge <input type="checkbox"/> breast pain <input type="checkbox"/> decreased libido <input type="checkbox"/> increased libido <input type="checkbox"/> frequent urination <input type="checkbox"/> decreased urination <input type="checkbox"/> erection problem
MUSCULOSKELETAL: <input type="checkbox"/> muscle aches or cramps <input type="checkbox"/> muscle weakness <input type="checkbox"/> joint pain/swelling <input type="checkbox"/> back pain <input type="checkbox"/> swelling in the extremities
SKIN: <input type="checkbox"/> abnormal mole <input type="checkbox"/> rash <input type="checkbox"/> nail problems <input type="checkbox"/> dry skin
NEURO: <input type="checkbox"/> Numbness or tingling hands or feet <input type="checkbox"/> dizziness <input type="checkbox"/> headache <input type="checkbox"/> tremors <input type="checkbox"/> trouble sleeping <input type="checkbox"/> memory loss <input type="checkbox"/> restless legs
PSY: <input type="checkbox"/> depression <input type="checkbox"/> irritable mood <input type="checkbox"/> anxiety <input type="checkbox"/> trouble sleeping <input type="checkbox"/> sleeping a lot
ENDO: <input type="checkbox"/> fatigue <input type="checkbox"/> hot flashes <input type="checkbox"/> always cold (cold intolerance) <input type="checkbox"/> hair loss <input type="checkbox"/> excess sweating
HEME / LYMPH: <input type="checkbox"/> swollen glands <input type="checkbox"/> easy bruising
ALLERGIC / IMMUNO: <input type="checkbox"/> runny nose <input type="checkbox"/> itching <input type="checkbox"/> hives
Please list any other symptoms:

ALL PATIENTS PLEASE READ AND SIGN BELOW.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any change in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of patient, parent, guardian

Date

Thank you for taking the time to complete both pages of this form. This helps us to better serve you!