_____ Date of Appointment: _____

Name Gender Age

Reason for Visit

What brings you to the office today?

Illness _____

_____

_____

_____

_____

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

_____

_____

_____

Current Medications

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following:

□ Adhesive Tape	□ Antibiotics	□ Latex
□ Barbiturates (Sleeping Pills)	□ Aspirin	□ Iodine
□ Local Anesthetics	□ Codeine	□ Sulfa

Do you have any other allergies?

Name	Reaction

Past Medical History

□ Alcoholism	□ Back Problems	□ Ear Problems	□ Hepatitis – A, B, or C	□ Measles	□ Skin Disorder
□ Allergies	□ Bleeding Disorder	□ Eating Disorder	□ High Blood Pressure	□ Migraines	□ Stomach Ulcer
□ Anemia	□ Blood Disease	□ Epilepsy	□ High Cholesterol	□ Osteoporosis	□ Substance Abuse
□ Anxiety Disorder	□ Blood Transfusion	□ Glaucoma	□ Joint Disorder	□ Pneumonia	□ Thyroid Disorder
□ Arthritis	□ Cancer	□ Gout	□ Kidney Disorder	□ Polio	□ Tuberculosis
□ Asthma	□ Diabetes	□ Heart Disease	□ Liver Disorder	□ Rheumatic Fever	□ Venereal Disease
□ AIDS / HIV	□ Depression	□ Heart Problems	□ Lung Disease	□ Stroke	

Hospitalizations & Surgeries

Reason	Date

Women Only:

# of Pregnancies	# of Miscarriages	# of Abortions	# of Living

Last PAP Smear	Last Mammogram	Birth Control Method

Family History

Has anyone in your family had any of the following conditions?

Please indicate which family member has the following:

GF – Grandfather GM – Grandmother M – Mother F – Father S – Sibling

Alcoholism _____	Cancer _____	Joint Disorder _____
Allergies _____	Depression _____	Kidney Disease _____
Alzheimer's _____	Diabetes _____	Liver Disease _____
Anemia _____	Epilepsy _____	Lung Disease _____
Anxiety _____	Genetic Disorder _____	Migraines _____
Arthritis _____	Glaucoma _____	Osteoporosis _____
Asthma _____	AIDS / HIV _____	Heart Disease _____
Psychiatric Disorders _____	Hepatitis _____	Stroke _____
Bleeding Disorder _____	High Cholesterol _____	
Substance Abuse _____	High Blood Pressure _____	
Blood Disorder _____	Thyroid Disorder _____	

Health Exams and Procedures

Please check and date the last time you had each exam or procedure performed?

	Month & Year		Month & Year
□ Cholesterol Test	_____	□ MRI	_____
□ Colonoscopy	_____	□ Physical Exam	_____
□ CT / CAT Scan	_____	□ Ultrasound	_____
□ EKG	_____	□ Echocardiogram	_____
□ Cardiac Stress Test	_____		

Immunizations

Please check and date all immunizations you have had.

	Month & Year		Month & Year
□ Hepatitis A	_____	□ Hepatitis B	_____
□ Hepatitis B	_____	□ HPV Vaccine	_____
□ Pneumonia	_____	□ Polio	_____
□ Influenza (Flu shot)	_____	□ Tetanus	_____
□ Meningitis	_____	□ MMR (measles, mumps, rubella)	_____

Name _____ Gender Age Date of Appointment: _____

Review of Systems

General
- □ Chills
- □ Dizziness
- □ Fainting
- □ Fever
- □ Hair Loss
- □ Hair Growth – Excessive
- □ Night Sweats
- □ Sleeping Problems
- □ Thirst – Excessive
- □ Weight Gain
- □ Weight Loss

Mental Health
- □ Anxiety
- □ Depression
- □ Loss of Interest
- □ Feeling Hopeless
- □ Hearing Voices
- □ Marital Problems
- □ Panic Attacks
- □ Trouble Concentrating
- □ Suicide – Thoughts/Attempts

Skin
- □ Acne
- □ Bruise Easily
- □ Changes in Moles
- □ Chills
- □ Dry / Sensitive Skin
- □ Eczema
- □ Hives
- □ Itching
- □ Rash
- □ Scars
- □ Sores That Won't Heal

Gastrointestinal
- □ Appetite Gain
- □ Appetite Loss
- □ Bloating
- □ Constipation
- □ Diarrhea
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Intestinal Disorder
- □ Lactose Intolerance
- □ Nausea
- □ Rectal Bleeding
- □ Stomach Pain
- □ Vomiting
- □ Vomiting Blood

Genitourinary
- □ Blood in Urine
- □ Lack of Bladder Control
- □ Frequent Urination
- □ Painful Urination

Neurological
- □ Coordination Problems
- □ Convulsions
- □ Difficulty Walking
- □ Learning Disabilities
- □ Light-headedness
- □ Memory Loss
- □ Numbness / Tingling
- □ Paralysis
- □ Seizures
- □ Speech Problems
- □ Tremors

ENT
- □ Bleeding Gums
- □ Blurred Vision
- □ Crossed Eyes
- □ Difficulty Swallowing
- □ Double Vision
- □ Earaches
- □ Ear Discharge
- □ HayFever
- □ Hoarseness
- □ Hearing Loss
- □ Nose-Bleeds
- □ Persistent Cough
- □ Persistent Runny Nose
- □ Recurring Sore Throat
- □ Ringing in Ears
- □ Sinus Problems
- □ Vision Halos

Women Only
- □ Abnormal PAP Smear
- □ Bleeding between Periods
- □ Breast Lump
- □ Extreme Menstrual Pain
- □ Hot Flashes
- □ Nipple Discharge
- □ Vaginal Discharge

Men Only
- □ Erection Difficulties
- □ Lump in Testicles
- □ Penile Discharge
- □ Sore on Penis

Musculoskeletal
- □ Back Pain
- □ Carpal Tunnel Syndrome
- □ Joint Pain
- □ Joint Swelling
- □ Neck Pain
- □ Shoulder Pain

Respiratory
- □ Coughing
- □ Coughing Up Blood
- □ Shortness of Breath
- □ Wheezing

Cardiovascular
- □ Chest Pains
- □ Irregular Heart Beat
- □ Rapid Heartbeat
- □ Circulation Problems
- □ Heart Palpitations
- □ Swelling of Ankles
- □ Varicose Veins

Other Symptoms: _____

_____

_____

Lifestyle Factors

Occupation: _____

Marital Status: _____

Are you sexually active? □ Yes □ No # of partners in past year _____

Do you have sex with Men, Women, or both? _____ # of lifetime partners _____

Do you wish to be checked for STDs? □ Yes □ No

Has anyone ever physically or verbally hurt you? □ Yes □ No

Have you ever smoked? □ Yes □ No Do you smoke now? □ Yes □ No # packs/day _____

Do you use recreational drugs? □ Yes □ No Types? _____ # times/week _____

How much alcohol do you drink per week? # drinks/week _____

How much caffeine do you drink per day? # drinks/day _____

How often do you exercise? # times/week _____

Guns in House: □ Yes □ No

Do you feel safe at home? □ Yes □ No

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