Patient Information

Patient Name

First Name

Last Name

Address

Address Line 1

Address Line 2

City

State

ZIP Code

Date of Birth

Email Address

Cell Phone

Home Phone

Work Phone

Social Security Number *

Do you have health insurance? *

Yes No

Patient Information

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Widowed

Employment

◯ Employed ◯ Unemployed ◯ Disabled ◯ Retired ◯ Student

Primary Care Provider

Referring Care Provider

Preferred Pharmacy

Preferred Pharmacy Phone

Preferred Pharmacy Address

Address Line 1

Address Line 2

City

State

ZIP Code

Symptoms

Tell us how you feel today: Do you have any symptoms the doctor should be aware of? (e.g. fever, chills, cough, chest pain, shortness of breath)

◯ Yes ◯ No

In the past 3 months, have you experienced any of the following symptoms?

- [ ] None
- [ ] Shortness of Breath
- [ ] Fever
- [ ] Chills
- [ ] Worsening Cough
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Abdominal pain
- [ ] Genralized Weakness
- [ ] Loss sense of taste
- [ ] Loss sense of smell
- [ ] Other:

Check any past/current patient problems

Have you traveled anywhere in 2020?

○ Yes ○ No

Have you been exposed to anyone who has tested positive for COVID-19?

○ Yes ○ No

Medical History

Medical History

- [ ] None
- [ ] Allergies
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Benign Prostatic Hypertrophy
- [ ] Blood Clots
- [ ] Cancer - Type
- [ ] Cerebrovascular Accident
- [ ] Cronary Artery Disease
- [ ] COPD (Emphysema)
- [ ] Crohn's Disease
- [ ] Depression
- [ ] Diabetes
- [ ] Gallbladder Disease
- [ ] GERD (Reflux)
- [ ] Hepatitis C
- [ ] Hyperlipidemia
- [ ] Hypertension
- [ ] Irritable Bowel Disease
- [ ] Liver Disease
- [ ] Migraine Headaches
- [ ] Myocardial Infarction
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] Peptic Ulcer Disease
- [ ] Renal Disease
- [ ] Seizure Disorder
- [ ] Thyroid Disease
- [ ] Other:

Check any past/current patient problems

Are you currently taking supplements or prescription medication?

○ Yes, I am. ○ I do not take any medications.

Do you suffer from any known allergies?

○ Yes ○ No

Exercise Activity

○ Moderate ○ Vigorous ○ Sedentary

Exercise days/week:

Alcohol use

○ No ○ Daily ○ Weekly ○ Less ○ Former User

›

Tobacco use

- [ ] No
- [ ] Daily
- [ ] Weekly
- [ ] Less
- [ ] Former User

Other illnesses otherwise not listed.

Have you had any surgeries in the past 5 years?

- [ ] Yes
- [ ] No

Previous Surgical History Please check the box next to any surgical procedures you've had

- [ ] None
- [ ] Angioplasty
- [ ] Angioplasty w/ Stent
- [ ] Appendectomy
- [ ] Arthroscopy Knee
- [ ] Back Surgery
- [ ] CABG (heart bypass)
- [ ] Carpal Tunnel Release
- [ ] Cataract Etraction
- [ ] Cholecystectomy
- [ ] Colectomy
- [ ] Colostomy
- [ ] Gastric Bypass
- [ ] Hernia Repair
- [ ] Hip Replacement
- [ ] Knee Replacement
- [ ] LASIK
- [ ] Liver Biopsy
- [ ] Pacemaker
- [ ] Small Bowel Resection
- [ ] Thyroidectomy
- [ ] Tonsillectomy
- [ ] ProstateBiopsy
- [ ] TURP
- [ ] Vasectomy
- [ ] Augmentation Mammoplasty
- [ ] Bilateral Tubal Ligation
- [ ] Breast Biopsy
- [ ] Cesarean Section
- [ ] D and C
- [ ] Hysterectomy
- [ ] Mastectomy
- [ ] Myomectomy
- [ ] Reduction Mammopasty
- [ ] TAH/BSO
- [ ] Vaginal Hysterectomy
- [ ] Other:

Family History Check if any family member(s) has had any of the following:

- [ ] Adopted
- [ ] Alcoholism
- [ ] Allergies
- [ ] Asthma
- [ ] Arthritis
- [ ] Blood Disease
- [ ] CAD (Heart Attack)
- [ ] Cancer
- [ ] CVA (Stroke)
- [ ] Depression
- [ ] Developmental Delay
- [ ] Diabetes
- [ ] Eczema
- [ ] Hearing Deficiency
- [ ] Hyperlipidemia (High Cholesterol)
- [ ] Hypertension (High Blood Pressure)
- [ ] Irritable Bowel Disease
- [ ] Learning Disability
- [ ] Mental Illness
- [ ] Tuberculosis
- [ ] Obesity
- [ ] Osteoarthritis
- [ ] Osteoporosis
- [ ] PVD
- [ ] Renal Disease
- [ ] Other:

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