Office Use Only: HT:_____ in. WT _____ lbs BMI _____.____ BP _____/_____ HR_____ Sat_____
NN_____ Pharmacy _____

1. Name

2. DOB

3 Problems or questions you'd like the doctor to address:

_____

_____

_____

_____

_____

4. Please circle all medical problems:

Problem	Date diagnosed
Asthma	
Cancer (where)	
Colon Polyps	
Diabetes	
Ever received blood?	
Heart disease	
High blood pressure	
High Cholesterol	
Kidney disease	
Liver disease (hepatitis)	
Lung disease	
Strokes	
Thyroid	
Ulcers:	

5. Other Medical Problems:

_____

_____

_____

_____

6. Past Surgeries Approximate Year

_____

_____

_____

_____

7. Medication allergies/ Severe Allergies

Medication	Reaction

8. Current Medications

Name	Size	Number taken	How Often

Name DOB

9. Family history:

A. Parents, siblings or children with heart attack Or stroke before age of 65?

B. Diabetes (who?)

C. Mothers major medical problems:

D. Father's major medical problems:

E. Does cancer run in your family? Who? Type?

F. Other diseases which run in your family?

10. List most recent test below

Test	When	Normal?
Saw Gynecologist		Y N
Stress test/ Heart Catheter		Y N
Diabetes Test		Y N
Rectal exam		Y N
Prostate Blood Test		Y N
Cholesterol		Y N
Colonoscopy		Y N
Tuberculosis testing		Y N
Bone Density		Y N

11. Vaccine and Year Given

Influenza	Shingles
Pneumonia	HPV (Gardasil)
Tetanus	Hepatitis A or B

12. Personal History:

A. Do you live alone?

B. Do you use recreational drugs?

C. If there are guns in the house, are they securely locked?

D. Who provides emotional support (family, friends, etc)?

E. Do you ever ride in the car without a seatbelt?

F. Do you ever drive drunk?

G. Do you exercise? How often?

H. Do you drink? How many per week?

I. If you drink, have you ever:

Felt the need to cut down?

Felt annoyed by criticism of drinking?

Had guilty feelings about drinking?

Taken a morning "eye opener"

J. Have you ever used tobacco?

Current of former?

When quit?

Number of pack per days?

K. Occupation?

L. Marital Status?

M. Number of children?

N. Do you wear a helmet when biking?

O. Do you wear sunblock when outside?

P. Number of servings of fruits or vegetables per day:

Name DOB

13. Circle if you CURRENTLY suffer:

Const.	Change in appetite	Cardio	Chest pain		Sexual dysfunction
	Chills		calf pain with walking	Endo	Cold intolerance
	Fatigue		Cool extremities		Excessive sweating
	Generalized weakness		Blue hands or feet		Heat intolerance
	Night sweats		Swollen ankles		Excessive thirst
	Paleness		Irregular heartbeat	Neuro	Difficulty speaking
	Weight gain		Cold painful hands		Headache
	Weight loss		Varicose veins		Memory impairment
ENMT	Difficulty swallowing	GI	Abdominal mass		Tingling/numbness
	Ear drainage		Abdominal pain		Seizures
	Facial pain		Bloating		Loss of consciousness
	Hoarseness		Blood in stool		Tremors
	Nasal drainage		Change in appetite	Integ.	Change in shape/size of mole
	Pain with swallowing		Change in bowel habits		Hair loss
	Runny nose		Constipation		Excessive hair growth
	Snoring		Decreased appetite		Itching
	Dizziness		Fecal incontinence		Rash
	Voice change		Flatulence		Ulcers
Eyes	Double vision		Heartburn		Hives
	Vision loss		Vomiting blood	MS	Back pain
RESP.	Rapid breathing		Yellow skin		Bone/joint symptoms
	Cough		Blood stool	Lymph.	Easy bleeding
	Shortness of breath		Nausea		Easy bruising
	Coughing up blood		Rectal bleeding		Swollen lymph nodes
	Nighttime shortness of breath		Reflux		Blood clots
	Need to sit up to breathe		Vomiting	Immun.	Allergies
	Stabbing pain with breathing	GU.	Decreased sex drive		Noisy breathing
	Muscus production		Genital herpes		Excessive urination

Name Signature Date