



Date: \_\_\_\_\_

Last Name	First Name	Middle Initial	
Home Phone	Work Phone	Cell Phone	
E-mail Address	Date of Birth	Marital Status	Age

**ADVANCED DIRECTIVES**

Do you have:  Durable Power of Attorney  Living Will  DNR(Do not Resuscitate)  None of these

Please let us know if you would like more information on any of the above items.

**MEDICATIONS & VITAMINS**

Please list all of your medications, prescription and nonprescription, and the dosage amount:

Medications	Dosage, how taken
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Please list all vitamins, supplements and other over the counter products.

Vitamins/OTC	Dosage, how taken
1.	
2.	
3.	
4.	

Please list medication ALLERGIES or medications you cannot take. Check here if NO allergies.

1.	3.
2.	4.

**PHARMACY INFORMATION**

Preferred Pharmacy Name	Pharmacy Phone Number	Pharmacy Address
Alternative Pharmacy Name	Pharmacy Phone Number	Pharmacy Address

Name: \_\_\_\_\_

### PAST MEDICAL HISTORY

Chief Complaint / Reason for Visit \_\_\_\_\_

Chronic Medical Problems \_\_\_\_\_

Please place a check mark in the box if you have ever experienced any of the following conditions Also, if you know the year, please include it.

	Year		Year		Year		Year
<input type="checkbox"/> Allergies		<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Gallbladder Disease		<input type="checkbox"/> MI/Heart Attack	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Cancer		<input type="checkbox"/> Reflux/GERD		<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Angina		<input type="checkbox"/> CVA/Stroke		<input type="checkbox"/> Hepatitis C		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> COPD/Lung		<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Peptic Ulcer	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Coronary Artery		<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Kidney/Renal	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Irritable Bowels		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Atrial Fibrillation		<input type="checkbox"/> Depression		<input type="checkbox"/> Liver Disease		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Migraine Headaches		<input type="checkbox"/> Other	

### PAST SURGICAL HISTORY

Please place a check mark in the box if you have ever had any of the following surgeries. Also, if you know the year, please include it.

	Year		Year		Year
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Colectomy (Colon		<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Angioplasty with Stent		<input type="checkbox"/> Colostomy (Wear a		<input type="checkbox"/> Small Bowel	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Thyroidectomy	
<input type="checkbox"/> Arthroscopic Knee Surgery		<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Hip Replacement		<input type="checkbox"/> Prostate Biopsy	
<input type="checkbox"/> CABG/Bypass Surgery		<input type="checkbox"/> Knee Replacement		<input type="checkbox"/> TURP / Prostate Removal	
<input type="checkbox"/> Carpal Tunnel		<input type="checkbox"/> Lasik		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Cataract		<input type="checkbox"/> Liver Biopsy		<input type="checkbox"/> Other	
<input type="checkbox"/> Cholecystectomy (Gallbladder)		<input type="checkbox"/> ORIF/ Hip Fracture			

### PAST DIAGNOSTICS

Please place a check mark in the box if you have ever had any of the following tests or procedures. Please include the last year this procedure was completed and the results, if known.

	Approximate Date	Results (if known)		Approximate Date	Results (if known)
<input type="checkbox"/> Colonoscopy			<input type="checkbox"/> Sigmoidoscopy		
<input type="checkbox"/> PPD			<input type="checkbox"/> Bone Density/ Dexa Scan		
<input type="checkbox"/> Lipid Panel			<input type="checkbox"/> Hepatitis C test		

### FAMILY HISTORY

Please check if any family member has had any of the following conditions. Include information even if the person is deceased.

Please check here if you are adopted.

	Mother	Father	Sister	Brother	Grandparents	Other
Cancer: Type						
Cancer: Type						
Irritable Bowel Disease						
Polyps						
Ulcerative Colitis / Crohn's Disease						
Other:						

Name: \_\_\_\_\_

**SOCIAL HISTORY & HEALTH MAINTENANCE**

Do you use tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Former	Type of tobacco used? _____
If cigarettes, # of packs per day? _____	Years smoked? _____ Date Quit? _____
Other tobacco (cans, cigars) per day? _____	Years smoked? _____ Date Quit? _____
Do you drink alcohol? <input type="checkbox"/> Currently <input type="checkbox"/> Never <input type="checkbox"/> Former	Date Quit? _____
Type of alcohol? _____	Daily amount? _____ How often? _____

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Year Retired \_\_\_\_\_

Vaccine:	Date of last:	Vaccine:	Date of last:
<input type="checkbox"/> Hepatitis A	1 <sup>st</sup> : _____ / 2 <sup>nd</sup> : _____	<input type="checkbox"/> Hepatitis B (3 shot series)	1 <sup>st</sup> : _____ / 2 <sup>nd</sup> : _____ / 3 <sup>rd</sup> : _____

Please check the box if you are **currently** experiencing any of the following:

**General**

- Chills
- Fatigue/Tiredness
- Fever
- Feel Lousy/Malaise
- Night Sweats
- Weight Gain
- Weight Loss

- Blood in Stools
- Change in Stools
- Constipation
- Diarrhea
- Heartburn
- Loss of Appetite
- Nausea
- Vomiting

- Headache
- Memory Loss
- Seizures
- Tremors

**Mood**

- Anxiety
- Depression
- Insomnia

**Eyes, Ears, Nose & Throat**

- Ear Drainage
- Ear Pain
- Eye Discharge
- Eye Pain
- Hearing Loss
- Nasal Drainage
- Sinus Pressure
- Sore Throat
- Visual Changes

**Urinary**

- Dribbling
- Dysuria/Pain on Urination
- Hematuria /Blood in Urine
- Polyuria/Excessive Urination
- Slow Stream
- Urinary Frequency
- Urinary Incontinence
- Urinary Retention

**Skin**

- Contact Allergy
- Hives
- Itching
- Mole Changes
- Rash
- Skin Lesion

**Respiratory/Lung**

- Chronic Cough
- Cough
- TB Exposure
- Shortness of Breath
- Wheezing

**Circulation**

- Blood Clots/Thrombophlebitis
- Ulcer of the Feet or Legs

**Musculoskeletal**

- Back Pain
- Joint Pain
- Joint Swelling
- Muscle Weakness
- Neck Pain

**Cardiovascular/Heart**

- Chest Pain
- Calf Pain with Walking/Claudication
- Swelling, Fluid Retention/Edema
- Heart Racing/Palpitations

**Metabolic/Endocrine**

- Brittle Hair
- Brittle Nails
- Cold Intolerance
- Hair Changes
- Heat Intolerance
- Hirsutism/Excessive Facial Hair
- Polydipsia/Excessive Thirst
- Polyphagia/ Excessive Eating

**Hematologic/Blood**

- Easy Bleeding
- Easy Bruising
- Lymphadenopathy/ Enlarged Lymph Nodes

**Gastrointestinal/GI**

- Abdominal Pain

**Neurological**

- Dizziness
- Extremity Numbness
- Extremity Weakness
- Gait Disturbance/Difficulty Walking

**Allergies**

- Environmental Allergies
- Food Allergies
- Seasonal Allergies

**Other**

- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
Patient/Parent/Care Giver Signature

\_\_\_\_\_  
Date