



Name:	Appointment Date:
Date of Birth:	Home Phone:
Cell Phone:	Work Phone:
Primary Care Physician:	Office Location of PCP:
Referring Physician (if different):	Office Location of Referring:
Email:	

REASON FOR TODAY'S VISIT: _____

PAST MEDICAL HISTORY:

CARDIAC	RESPIRATORY	GENITOURINARY / REPRODUCTIVE
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Many urine infections
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Infertility
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Emphysema	Males:
<input type="checkbox"/> Stroke		<input type="checkbox"/> Erectile Dysfunction
<input type="checkbox"/> Mitral valve prolapse	GASTROINTESTINAL	
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Ulcers	Females:
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Gestational Diabetes
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Irregular periods
MUSCULOSKELETAL	<input type="checkbox"/> Diverticulitis	Date of last period: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Crohns / colitis	Age of Menopause: _____
<input type="checkbox"/> Spine or Hip Fracture		
<input type="checkbox"/> Other _____	HEMATOLOGIC	CANCER
	<input type="checkbox"/> Easy bleeding / bruising	<input type="checkbox"/> Type: _____
	<input type="checkbox"/> History of blood clot	
NEUROLOGIC	ENDOCRINE	
<input type="checkbox"/> Spine / back injury	<input type="checkbox"/> Diabetes	Females:
<input type="checkbox"/> Seizures	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Polycystic Ovarian Syndrome
<input type="checkbox"/> Migraines	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Unwanted facial or body hair
<input type="checkbox"/> Recurrent headaches	<input type="checkbox"/> High cholesterol	Other: _____
	<input type="checkbox"/> Steroid use	_____
	<input type="checkbox"/> Excessive weight gain	_____

PAST SURGICAL HISTORY: (Please list your surgeries and approximate dates)

(Turn page over)



LIFESTYLE AND SOCIAL HISTORY:

Marital Status: Single Married Divorced Widowed Separated

Who do you live with: _____ Number in Household? _____

Current Occupation: _____ Exercise (Type & Frequency): _____

Diet: _____

Do you currently use tobacco products: YES NO If so, type: _____ How much?: _____

For how long?: _____

Would you like assistance with tobacco cessation? YES NO

If not currently using tobacco, did you use tobacco in the past? YES NO If so, type: _____

How much?: _____ For how long?: _____

Alcohol Intake: Drinks per day / week: _____

Do you use recreational drugs? YES NO If no, have you ever? YES NO If so, what and how often? _____

REVIEW OF SYSTEMS: Please check if you are currently experiencing any of the following:

GENERAL WELL-BEING	CARDIOVASCULAR	EARS, NOSE, THROAT, MOUTH	
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Sinus Problems	
<input type="checkbox"/> Fever	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Swelling	<input type="checkbox"/> Ringing in the Ears	
<input type="checkbox"/> Excessive Thirst	RESPIRATORY		
<input type="checkbox"/> Excessive Hunger	<input type="checkbox"/> Coughing	<input type="checkbox"/> Difficulty Swallowing	
<input type="checkbox"/> Problems Sleeping	<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Hoarseness	
<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Wheezing	BREAST	
<input type="checkbox"/> Cold Intolerance	EYES		
BLOOD SYSTEM			
<input type="checkbox"/> Bleed Easily	<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Pain	
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Contacts / Glasses	<input type="checkbox"/> Nipple Discharge	
GASTROINTESTINAL			
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Breast Lump	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Dry Eye	MUSCULOSKELETAL	
<input type="checkbox"/> Nausea / Vomiting	NEUROLOGICAL		
<input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Dizziness	URINARY / GYNECOLOGIC	
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Blood in Urine	
PSYCHOLOGICAL			
<input type="checkbox"/> Depression	<input type="checkbox"/> Numbness	<input type="checkbox"/> Painful Urination	
<input type="checkbox"/> Severe Mood Swings	<input type="checkbox"/> Difficulty walking	Women: <input type="checkbox"/> Irregular Periods	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Tremors	SKIN	
<input type="checkbox"/> Confusion	SLEEP DISTURBANCE		
<input type="checkbox"/> Severe Agitation	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Acne	
	<input type="checkbox"/> Difficulty Falling Asleep	<input type="checkbox"/> Hair Loss	
	<input type="checkbox"/> Waking up frequently at night	<input type="checkbox"/> Excessive Hair Growth	
	<input type="checkbox"/> Excessive sleepiness during day	<input type="checkbox"/> Dryness	
	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Rash	

(see page 3)



Name:	Date of Birth:
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PERIODIC HEALTH SCREENING: *When was your last:*

Flu Vaccine:	Pneumonia Vaccine:	Dental Exam:
Dilated Eye Exam:	Last Foot Exam:	Podiatrist Name:
Bone Densitometry:	Ophthalmologist Name:	

FAMILY HISTORY – Have any of your family members ever had any of the following? Please cross out any family listed below that does not apply to you.....(Example: if you don't have a sister, just cross out sister)

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Arthritis – Rheum								
Arthritis – Osteoporosis								
Asthma								
Cancer								
Diabetes								
Heart Failure								
High Cholesterol								
Hypertension								
Migraines								
Rashes / Skin Problems								
Seizures								
Stroke								
Thyroid Disease								

Are there any concerns that you would like to discuss at today's visit? _____
