

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

DOB: \_\_\_\_\_

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

MR#: \_\_\_\_\_

Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information, and will be kept in your electronic medical record.

Were you referred by another physician? If so, who?

\_\_\_\_\_

Please describe the reason for your visit today. Please include the date of onset and any symptoms associated with the problem.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications**

Medication name	Dose and frequency	Need Refill (Y/N)?

**Allergies** (foods and drugs)

Please indicate type of reaction next to each.

\_\_\_\_\_

\_\_\_\_\_

**Advanced Directives**

Do you have Advanced Directives? (such as living will, power of attorney, etc.)    Yes\_\_\_ No\_\_\_

If yes, please specify.

\_\_\_\_\_

**Past Medical History/Problems** (check all that apply)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Pap Smear  | <input type="checkbox"/> Depression                                  | <input type="checkbox"/> Hepatitis B                 | <input type="checkbox"/> Rheumatoid Arthritis                       |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Diabetes, Gestational                       | <input type="checkbox"/> Hepatitis C                 | <input type="checkbox"/> Seizure Disorder                           |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Diabetes Type 1                             | <input type="checkbox"/> Hypertension                | <input type="checkbox"/> Skin Cancer                                |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Diabetes Type 2                             | <input type="checkbox"/> Hyperthyroidism             | <input type="checkbox"/> Substance Abuse                            |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diverticulosis                              | <input type="checkbox"/> Hypothyroidism              | <input type="checkbox"/> Thyroid Disorder                           |
| <input type="checkbox"/> Bipolar Disorder    | <input type="checkbox"/> DVT- <b>Blood Clot in Deep Vein</b>         | <input type="checkbox"/> Kidney Stone                | <input type="checkbox"/> Tuberculosis                               |
| <input type="checkbox"/> Blood Transfusion   | <input type="checkbox"/> <b>Cholesterol Problems</b>                 | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> <b>Urinary tract infection – recurrent</b> |
| <input type="checkbox"/> Breast Ca.          | <input type="checkbox"/> Fibrocystic Breast Disease                  | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> Varicose Veins/Phlebitis                   |
| <input type="checkbox"/> Cervical Ca.        | <input type="checkbox"/> GERD- <b>Acid Reflux</b>                    | <input type="checkbox"/> Osteoarthritis              | <input type="checkbox"/> <b>Migraine</b>                            |
| <input type="checkbox"/> Chronic Back Pain   | <input type="checkbox"/> Gout  | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> <b>Menstrual Problems</b>                  |
| <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> <b>Gastrointestinal Bleed (upper/lower)</b> | <input type="checkbox"/> Peptic Ulcer Disease        | <input type="checkbox"/> <b>Lack of sex drive</b>                   |
| <input type="checkbox"/> COPD                | <input type="checkbox"/> Coronary Heart Disease                      | <input type="checkbox"/> Peripheral Vascular Disease |   |
| <input type="checkbox"/> Crohns Disease      | <input type="checkbox"/> Congestive Heart Failure                    | <input type="checkbox"/> Prostate Cancer             | <input type="checkbox"/> <b>Erectile Dysfunction</b>                |
| <input type="checkbox"/> CVA /Stroke         | <input type="checkbox"/> Valvular Heart Disease                      | <input type="checkbox"/> Renal Failure               | <input type="checkbox"/> <b>Back Pain</b>                           |
| <input type="checkbox"/> Dementia            | <input type="checkbox"/> Hepatitis A                                 | <input type="checkbox"/> Renal Insufficiency         | <input type="checkbox"/> <b>Disabilities</b>                        |

**NO MEDICAL PROBLEMS**

Please explain any items you checked and list any medical problems not included:

---



---



---

**Past Surgical History** (check all that apply)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> No surgeries                | <input type="checkbox"/> CABG                     | <input type="checkbox"/> Knee Arthroscopy/scope   | <input type="checkbox"/> Transplant Lung  |
| <input type="checkbox"/> Abdominal Surgery-type      | <input type="checkbox"/> Carotid Endarterectomy   | <input type="checkbox"/> Knee Replacement         | <input type="checkbox"/> Transplant Kidney  |
| <input type="checkbox"/> Aneurysm Repair             | <input type="checkbox"/> Cataract Extraction      | <input type="checkbox"/> Lumbar Discectomy        | <input type="checkbox"/> Sinus Surgery  |
| <input type="checkbox"/> Appendectomy                | <input type="checkbox"/> C-Section                | <input type="checkbox"/> Mastectomy               | <input type="checkbox"/> Uterus/Ovary Surgery                                     |
| <input type="checkbox"/> Left Aortic-Femoral Bypass  | <input type="checkbox"/> Cervical Discectomy      | <input type="checkbox"/> Mitral Valve Replacement | <input type="checkbox"/> Vasectomy  |
| <input type="checkbox"/> Right Aortic-Femoral Bypass | <input type="checkbox"/> Cholecystectomy          | <input type="checkbox"/> Nephrectomy              | <input type="checkbox"/> Surgery Complications                                    |
| <input type="checkbox"/> Bilateral A-F Bypass        | <input type="checkbox"/> Colon Resection          | <input type="checkbox"/> Stent Placement          | <input type="checkbox"/> Yes <input type="checkbox"/> No                          |
| <input type="checkbox"/> Aortic Valve                | <input type="checkbox"/> Craniotomy               | <input type="checkbox"/> Lung Resection           | <input type="checkbox"/> Anesthesia Complications                                 |
| <input type="checkbox"/> Breast Augmentation         | <input type="checkbox"/> Gastric Lap Band         | <input type="checkbox"/> Prostatectomy            | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Breast Lumpectomy           | <input type="checkbox"/> Cryn Surgery             | <input type="checkbox"/> Rotator Cuff Re          | <input type="checkbox"/> Other  |
| <input type="checkbox"/> Breast Reduction            | <input type="checkbox"/> Hernia Repair – Inguinal | <input type="checkbox"/> Tonsillectomy            |   |
| <input type="checkbox"/> Bronchoscopy                | <input type="checkbox"/> Hernia Repair- Umbilical | <input type="checkbox"/> Tubal Ligation           |   |
| <input type="checkbox"/> Cardiac/ Heart Cath         | <input type="checkbox"/> Hip Replacement          | <input type="checkbox"/> Transplant Heart         |   |
| <input type="checkbox"/> Carpal Tunnel               | <input type="checkbox"/> Hysterectomy w/BSO       | <input type="checkbox"/> Transplant Liver         |   |

Please list any surgeries not included:

---



---



---



**Preventative Care:**

We strongly believe that prevention is the key to keeping you happy and healthy. We closely follow national recommendations in screening for cancer, heart disease, cholesterol problems, diabetes, high blood pressure, osteoporosis, and many vaccine preventable diseases.

In order to help us with our goal please also fill out the following.

When was your last physical exam or well woman exam? \_\_\_\_\_

<p><b>Cholesterol</b>        Have you had your cholesterol levels tested in the last 5 years?  <input type="checkbox"/> Yes      <input type="checkbox"/> No        _____  <input type="checkbox"/> Normal      <input type="checkbox"/> High        If high, what was the number _____</p> <p><b>Colon Cancer Screening</b> (for patients over 50)        Have you ever had colon cancer screening? <input type="checkbox"/> Yes <input type="checkbox"/> No        Colonoscopy? If so when _____        Where _____</p> <p style="background-color: yellow;"><b>Findings</b></p> <p style="background-color: yellow;"><b>Suggested follow up:</b></p> <p>Sigmoidoscopy? If so when _____        Where _____        Barium Enema? If so when _____        Where _____        Hemocult/ If so when _____        blood in stool? Where _____</p> <p><b>Immunizations</b>        When was your last tetanus vaccine _____        When was your last flu vaccine _____        When was your last pneumonia vaccine _____</p> <p><b>Osteoporosis (bone thinning and weakening )</b>        When was your last bone mineral density        _____        Where _____        Do you know the results _____</p> <p style="background-color: yellow;"><b>Last Eye Exam:</b></p> <p style="background-color: yellow;"><b>Family history of Glaucoma? Yes__ No__</b></p>	<p><b>Males only</b>  <b>Testicular Cancer</b>        When was your last testicular exam _____</p> <p><b>Prostate Cancer Screening</b>        When was your last exam _____        PSA? _____</p> <p><b>Females only</b>  <b>Cervical Cancer</b>        When was your last pap smear _____        Where _____  <input type="checkbox"/> Normal      <input type="checkbox"/> Abnormal        Have you had a hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No        Have you ever been diagnosed with cervical, uterine or ovarian cancer  <input type="checkbox"/> Yes      <input type="checkbox"/> No        What type _____</p> <p><b>Mammogram</b>        When was your last breast exam _____        When was your last mammogram _____        Where _____  <input type="checkbox"/> Normal      <input type="checkbox"/> Abnormal</p>
---	---

**Review of Systems** (circle all that apply)

Please indicate whether you have recently (last month) had problems with any of the following.

<b>General:</b>	Decreased appetite    Dizziness    Fatigue    Fever    Weakness    Unintentional weight loss Weight gain
<b>Eyes:</b>	Eye discharge    Halos    Eye irritation    Recent visual changes
<b>Ears, Nose and Throat:</b>	Allergy/sinus problems    Difficulty swallowing    Disruptive snoring    Earache    Hearing loss    Nasal congestion    Postnasal drip    Runny nose    Sneezing    Voice change
<b>Cardiovascular:</b>	Chest pain    Leg cramps with exertion    Palpitations/irregular heartbeats Swelling of the hands or feet    Passing out
<b>Respiratory:</b>	Chest congestion    Cough    Coughing up blood    Shortness of breath Sleep disturbance due to breathing    Wheezing
<b>Gastrointestinal:</b>	Abdominal bloating    Abdominal pain    Change in bowel habits    Difficulty swallowing Constipation    Diarrhea    Acid reflux/indigestion    Black, tarry stool    Nausea Rectal bleeding    Vomiting
<b>Genitourinary: Female:</b>	Decreased libido    Breast pain    Pain with urination    Pain with intercourse Blood in the urine    Urinary incontinence    Nipple discharge    Pelvic pain Urinary frequency    Urinary urgency    Vaginal discharge    Vaginal dryness
<b>Genitourinary: Male:</b>	Decreased libido    Decreased urinary flow    Discharge    Pain with urination Erectile dysfunction    Blood in the urine    Urinary incontinence    Urinating at night Urinary frequency    Urinary hesitancy
<b>Musculoskeletal:</b>	Back pain    Joint pain    Joint swelling    Muscle aches    Muscle cramps
<b>Dermatologic:</b>	Acne    Hair loss    Nail problems    Itching    Rash    Changing moles
<b>Neurological:</b>	Difficulty walking    Double vision    Frequent falling    Headaches    Muscle weakness    Numbness    Seizures    Sudden loss of vision    Tremors
<b>Psychiatric:</b>	Anxiety    Depression    Insomnia
<b>Endocrine:</b>	Excessive thirst    Excessive urination    Intolerance to cold    Intolerance to heat
<b>Hematological:</b>	Easy bruising    Abnormal bleeding    Enlarged lymph nodes
<b>Allergy:</b>	Itchy eyes    Hives    Seasonal allergies