

Name: _____

Date of Birth: _____

What are the **most important** issue you want to discuss at today's office visit?

1. _____

2. _____

MEDICATIONS	Dose	Frequency	Reason taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST OR PRESENT MEDICAL CONDITIONS - CHECK ALL THAT APPLY

- | | | |
|---|---|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> DVT / Pulmonary embolism | <input type="checkbox"/> Epilepsy /seizure |
| <input type="checkbox"/> Type 2 or 1 diabetes | <input type="checkbox"/> Obstructive sleep apnea | <input type="checkbox"/> Stroke (CVA) |
| Diabetes Complications: | <input type="checkbox"/> Positive TB skin test (PPD) | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Kidney (nephropathy) | <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Nerve (neuropathy) | <input type="checkbox"/> Chronic kidney insufficiency | <input type="checkbox"/> Migraine or Headaches |
| <input type="checkbox"/> Eye (retinopathy) | <input type="checkbox"/> Gastroesophageal reflux | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Barrett's esophagus | <input type="checkbox"/> Large prostate (BPH) |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Crohn's / Ulcerative Colitis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid nodule / goiter | <input type="checkbox"/> Celiac sprue | <input type="checkbox"/> Anxiety / depression |
| <input type="checkbox"/> Elevated blood sugar | <input type="checkbox"/> History of colon polyps | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Osteopenia / Osteoporosis | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Macular degeneration |
| <input type="checkbox"/> Coronary artery disease / heart attack | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Low vitamin B12 or D |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Degenerative joint disease | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Carotid stenosis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cancer: |
| <input type="checkbox"/> Blood vessel disease (PVD) | <input type="checkbox"/> Systemic lupus erythematosus | _____ |
| <input type="checkbox"/> COPD / Asthma | <input type="checkbox"/> Gout | _____ |
| <input type="checkbox"/> Asbestos exposure | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Other: |
| | <input type="checkbox"/> Alzheimer's / dementia | _____ |
| | | _____ |

Women only:

Number of Pregnancies _____

of live births _____

of Miscarriage/Abortion _____

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ALLERGIES TO MEDICATIONS OR FOOD

Medications / Food

Reaction

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES – CHECK ALL THAT APPLY

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> C-section	<input type="checkbox"/> Joint Surgery (list): _____
<input type="checkbox"/> Gallbladder surgery	<input type="checkbox"/> Thyroid Surgery	_____
<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Back/Neck Surgery	_____
<input type="checkbox"/> Prostate Surgery	<input type="checkbox"/> Cataract Removal	<input type="checkbox"/> Other Surgery (list): _____
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Transplant (list): _____	_____
<input type="checkbox"/> Ovary Removal	<input type="checkbox"/> Hernia (list): _____	_____
<input type="checkbox"/> Breast Surgery	_____	_____
<input type="checkbox"/> Breast Biopsy	_____	_____
<input type="checkbox"/> Heart Bypass/Stent	_____	_____
<input type="checkbox"/> Bariatric Surgery	_____	_____

FAMILY HEALTH HISTORY

	Major medical problems	Age of death	Cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Sibling (#____)	_____	_____	_____
Children (#____)	_____	_____	_____

In addition to completing the above information, please check all that apply to family history:

- | | |
|---|--|
| <input type="checkbox"/> Breast or Ovarian Cancer | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Early Heart Attack (before age 55 for men and 65 for women) |

SOCIAL

Occupation: _____ Marital Status: _____ Living Will? YES NO

Name: _____ Date of Birth: _____

Tobacco Use

- Never
- Former Use.... Year quit _____ # Years smoked _____ # Packs/day _____
- Current Use.... Age started _____ # Packs/day _____

Alcohol Use

Did you have a drink containing alcohol in the past year? YES NO

How often did you have a drink containing alcohol?

- Monthly or less
- 2 to 3 times a WEEK
- 2 to 4 times a MONTH
- 4 or more times a WEEK

How many alcoholic drinks did you have on a typical day?

- 1 – 2
- 3 – 4
- 5 – 6
- 7 – 9
- 10 or more

How often did you have 6 or more drinks on one occasion in the past year?

- Never
- Monthly
- Daily or almost daily
- Less than monthly
- Weekly

PREVENTATIVE AND WELLNESS

Colonoscopy (month/year) _____ Result: _____

Eye exam (month/year) _____ Result: _____

Men only: Prostate blood test (month/year) _____

Women only: Bone density (month/year) _____ Gynecologist name _____

Mammogram (month/year) _____ Result: _____

Pap smear (month/year) _____ Result: _____

IMMUNIZATIONS

Tetanus (year) _____ Pneumovax (year) _____ Prevnar (year) _____

Hepatitis A (year) _____ Hepatitis B (year) _____ Chickenpox (year) _____

Shingles (year) _____ Gardasil/HPV (year) _____ Flu (month/year) _____

Fall Risk

Mobility Status (circle): Walking Walking with Assistance Wheelchair

Have you fallen in the past year (circle)? YES NO

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Mood Questions

Do you have little interest or pleasure in doing things? YES NO

Are you feeling down, depressed, or hopeless? YES NO

SPECIALIST PHYSICIANS that you see regularly (please list all)

Name of your previous PCP (including city/state): _____

SYSTEM REVIEW - indicate if you have had any of the below symptoms in last 2 months

Rate your pain on a scale (0 = no pain; 10 = debilitating pain) _____

Skin rash, sore, or change of a mole? YES NO

Excessive thirst or urination? YES NO

Significant headaches, slurred speech? YES NO

Double or blurred vision? YES NO

Diminished hearing or hoarseness? YES NO

Desire for hearing test? YES NO

Cough, shortness of breath, or wheezing? YES NO

Chest pain/pressure; rapid or irregular heartbeat? YES NO

Awakening at night short of breath? YES NO

Abnormal swelling in the legs or feet? YES NO

Difficulty swallowing, heartburn, nausea, or vomiting? YES NO

Significant constipation or diarrhea; bloody or black bowel movements? YES NO

Pain or stiffness in your joints? YES NO

Do you feel you are at risk for sexually transmitted disease? YES NO

Weight loss of 10 pounds or more during the last 6 months? YES NO

Disruptive snoring? YES NO

Have others witnessed you stop breathing while sleeping? YES NO

Abnormal nipple discharge or breast lump? YES NO

Involuntary leakage of urinary? YES NO