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

- □ Hypertension
- □ Type 2 or 1 diabetes

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

  _____

  _____
- □ Other:

  _____

  _____

  _____

Women only:

Number of Pregnancies _____ # of live births _____ # of Miscarriage/Abortion _____

Name: _____ Date of Birth: _____

ALLERGIES TO MEDICATIONS OR FOOD

Medications / Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES – CHECK ALL THAT APPLY

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

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:

☐ Breast or Ovarian Cancer
☐ Colon Cancer
☐ Prostate Cancer
☐ 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 4 times a MONTH
- ☐ 2 to 3 times a WEEK
- ☐ 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
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

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

Name: _____ Date of Birth: _____

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 <u>2 months</u>

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