Name: _____ Date of Birth: _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____
Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1.	
2.	
3.	

FAVORITE PHARMACY(s)

1. _____
2. _____

MEDICATIONS, VITAMINS, HERBS, AND/OR SUPPLEMENTS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

	DRUG NAME	STRENGTH	# OF PILLS	FREQUENCY TAKEN	PRESCRIBING PROVIDER
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

PROVIDERS WHO HAVE TREATED YOU

	PROVIDER'S NAME	CITY	STATE	DATE LAST SEEN
1.				
2.				
3.				
4.				
5.				

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Chickenpox Date: _____
- ☐ Flu Shot Date: _____
- ☐ Hepatitis A Date: _____
- ☐ Hepatitis B Date: _____
- ☐ Pneumonia Date: _____
- ☐ Tdap (*Tetanus and pertussis*) Date: _____
- ☐ Tetanus Date: _____
- ☐ Zostavax (*Shingles*) Date: _____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date _____ ☐ Abnormal
Last Mammogram Date _____ ☐ Abnormal
Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
☐ Cesarean sections If yes, then number: _____
Date last Colonoscopy_____ ☐ Abnormal
Date Last Dexa Scan_____ ☐ Abnormal

☐ Vaginal bleeding
☐ Vaginal itching, burning, or discharge
☐ Wake in the night to go to the bathroom
☐ Hot flashes
☐ Breast lump or nipple discharge
☐ Painful intercourse
☐ Sexually active
Current sexual partner is ☐ Female ☐ Male
Do you use condoms? ☐ Yes ☐ No
☐ Interested in being screened for STD's

(MEN ONLY) UROLOGY HISTORY

☐ How many times are you up at night to urinate?_____
☐ Difficulty starting / stopping urine stream?
☐ Problem completely emptying bladder?
Date last prostate exam _____
Date last Colonoscopy_____ ☐ Abnormal
Date last Dexa Scan_____ ☐ Abnormal

☐ Difficulty with intercourse?
☐ Sexually active?
Current sexual partner is ☐ Female ☐ Male
Do you use condoms? ☐ Yes ☐ No
☐ Interested in being screened for STD's

SOCIAL HISTORY

Occupation_____

Education ☐ Less than 8th grade ☐ High school
☐ 2 year college ☐ 4 year college
☐ Post graduate

Marital Status ☐ Married ☐ Single
☐ Divorced ☐ Separated ☐ Widowed
☐ Domestic partner

Exercise Level
Frequency:_____days/week
Length of each session:_____
of Exercise(s) done:
_____

Caffeine Intake
Type:_____
How many cups/day?_____

Alcohol
Do you drink alcohol? ☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week
☐ > 3 times a week
How many drinks per week? _____

Tobacco Do you use tobacco? ☐ Yes ☐ No
If not currently, did you ever use Tobacco? ☐ Yes ☐ No
☐ Cigarettes - _____pks./day
☐ Chew - _____/day
☐ Cigars - _____/day
☐ # of years_____
Or year quit _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:_____
_____

Living arrangements
☐ Live in own home
☐ Live with Family
☐ Live in assisted living Facility
Name: _____

Advanced Directives
☐ Living Will
☐ Power of Attorney

Assistive Device
☐ Cane
☐ Walker
☐ Wheel Chair
☐ None

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Cirrhosis
- ☐ Claustrophobic
- ☐ COPD/ Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes - Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Osteoporosis
- ☐ Polio
- ☐ Prostate Problems
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other

Other:_____

_____

_____

PAST HOSPITALIZATIONS AND SURGERIES

	REASON FOR HOSPITALIZATION OR SURGERY	YEAR	HOSPITAL
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:_____	Y/N	_____	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Date last dental exam:_____

Endocrine
- ☐ Fatigue
- ☐ Increased
  - ☐ Thirst
  - ☐ Hunger
  - ☐ Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_____

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

Please add any other information about your health that you would like your provider to know here: _____

_____

_____

_____

_____ _____

Patient, Guardian, or Caregiver Signature Date