**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_MRN# \_\_\_\_\_\_\_\_\_\_

Last name First name MI Preferred name

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (with area code) Cell Phone (with area code) Work Phone (with area code

**In case of Emergency** Notify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Relationship to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (with area code) Cell Phone (with area code) Work Phone (with area code

**PERSONAL HISTORY:** Please comment on all yes answers in comment section or on an additional sheet

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Have You Had?** | **Y** | **N** |  | **Y** | **N** |  | **Y** | **N** |  | **Y** | **N** |
| ADD/ADHD |  |  | Depression/Anxiety |  |  | Menstrual problems |  |  | Sinus condition |  |  |
| Anemia |  |  | Diabetes (I or II) |  |  | Mononucleosis |  |  | Sleep Disturbance |  |  |
| Asperger Syndrome |  |  | Disordered Eating |  |  | Orthopaedic |  |  | Stomach Disorder |  |  |
| Asthma |  |  | Eye problem |  |  | Pneumonia |  |  | Strep throat, recurrent |  |  |
| Back Problem |  |  | Gallbladder disease |  |  | POTS |  |  | Surgery |  |  |
| Bipolar Disorder |  |  | Head injury |  |  | Pregnancy |  |  | Appendectomy |  |  |
| Bronchitis, recurrent |  |  | Headache, recurrent |  |  | PTSD |  |  | Tonsillectomy |  |  |
| Cancer |  |  | Heart condition/Murmur |  |  | Recent International Travel |  |  | Other |  |  |
| Celiac Disease |  |  | Hepatitis |  |  | Recurrent Concussions |  |  | Thyroid disorder |  |  |
| Chickenpox |  |  | High Blood Pressure |  |  | Seizures |  |  | Tuberculosis |  |  |
| Counseling |  |  | HIV/AIDS |  |  | Self Harm |  |  | Urinary tract infection |  |  |
| Crohn’s/Ulcerative Colitis |  |  | Kidney disorder |  |  | Sexually transmitted disease |  |  | Weight gain/loss, recent |  |  |

**HOSPITALIZATIONS/SURGERY**: □ None Reason(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS, HERBALS, MINERALS:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES: (Medications/Environment/Food)**

|  |  |
| --- | --- |
| ***Type*** | ***Reaction (rash/tongue swelling etc)*** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**SOCIAL HISTORY:**

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use: €Never €In the Past €Presently-How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Use: €None €Occasional\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ €Daily. How much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational/Street Drugs €No €Yes If so, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMEDIATE FAMILY MEDICAL HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | ***No*** | ***Yes*** | ***Relationship*** |  | ***No*** | ***Yes*** | ***Relationship*** |
| High Blood Pressure |  |  |  | Nervous Disorder |  |  |  |
| Blood or clotting disorder |  |  |  | Drug/Alcohol Abuse |  |  |  |
| Glaucoma |  |  |  | Diabetes |  |  |  |
| Autoimmune disease |  |  |  | Heart Disease |  |  |  |
| Cancer |  |  |  | Kidney Disease |  |  |  |
| Liver Disease |  |  |  | Seizures |  |  |  |
| Thyroid Problems |  |  |  | Stroke |  |  |  |
| HIV |  |  |  | Tuberculosis |  |  |  |
| Pneumonia |  |  |  | Psychiatric/mental health disease |  |  |  |
| Arthritis |  |  |  | Family history of sudden death before age 50 |  |  |  |

**HEALTH MAINTENANCE**

*Describe your exercise*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Do you wear a seatbelt?* €Yes €No

*Sexual Active:* €yes €no with €Men €Women €both €one partner

*Women*: Last menstrual period\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle or check the any symptoms:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the past **two weeks**, how often have you been bothered by any of the follow problems? | **NOT AT ALL** | **SEVERAL DAYS** | **MORE THAN ONE-HALF THE DAYS** | **NEARLY EVERY DAY** |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

***\*\*Please note that any acute or chronic issues addressed at a preventive visit may incur a copay or additional cost\*\****

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **General:**  □ Weight loss  □ Weight gain  □ Fatigue/weakness  □ Fever  □ Trouble sleeping  □ None | **Throat:**  □ Tooth/gum pain  □ Sore throat □ Hoarseness  □ Post nasal drip □ Stiffness  □ Swollen glands  □ None | | **Gastrointestinal:**  □ Heartburn □ Constipation  □ Abdominal pain □ Hemorrhoids  □ Change in appetite□ Nausea  □ Vomiting □ Gas  □ Change in bowel habits  □ Rectal bleeding, coffee-ground stool □ Diarrhea □ None | | **Skin:**  □ Rashes □ Acne  □ Dryness/ itching  □ Color changes with cold  □ Hair and nail changes  □ Easy bruising  □ Mass □ None |
| **Eyes:**  □ Change in vision  □ Glasses or contacts  □ Pain/redness □ Glaucoma  □ Something in eye feeling  □ Last eye exam:\_\_\_\_\_\_\_\_\_\_\_\_  □ None | **Breasts:**  □ Lumps  □ Pain  □ Discharge  □ None | | **Urinary:**  □ Frequency  □ Burning or pain  □ Blood in urine  □ None | | **Neurologic:**  □ Headache  □ Dizziness/fainting  □ Weakness □ Memory loss  □ Numbness/tingling  □ Loss of consciousness  □ None |
| **Ears:**  □ Decreased hearing  □ Ringing in ears  □ Earache  □ Drainage  □ None | **Cardiovascular:**  □ Chest pain/ tightness  □ Skipped heartbeat  □ High blood pressure  □ Heart murmur  □ None | | **Genital**  □ Pain with sex  □ Hernia □ Sexually active  □ Penile discharge  □ Vaginal discharge  □ Itching/rash □ Sores  □ Masses □ None | | **Psychiatric:**  □ Nervousness  □ Anxiety □ Depression  □ Panic attacks □ Insomnia  □ Stress □ Self injury  □ Thoughts of suicide  □ None |
| **Nose:**  □ Stuffiness  □ Discharge □ Itching  □ Nosebleeds  □ Sinus pain  □None | **Respiratory:**  □ Cough □ Sputum  □ Coughing up blood □ Night sweats  □ Shortness of breath □ Wheezing  □ Coughing up mucous  □ Painful breathing □None | | **Musculoskeletal:**  □ Muscle pain/ weakness  □ Joint pain/ stiffness □ Trauma  □ Back pain □ Neck pain  □ Calf pain/cramps □ None | | **Endocrine:**  □ Cold/ heat intolerance  □ Frequent urination  □ Thirst  □ Menstrual cycle irregular  □None |
| **Vitals:**  HR\_\_\_\_\_\_\_\_\_BP\_\_\_\_\_\_\_\_\_RR\_\_\_\_\_\_\_\_\_T\_\_\_\_\_\_\_\_\_  Sa02\_\_\_\_\_\_\_\_Head Circum\_\_\_\_\_\_\_\_  HT\_\_\_\_\_\_\_\_\_\_\_WT\_\_\_\_\_\_\_\_\_\_BMI\_\_\_\_\_\_\_\_LMP\_\_\_\_  Lab Results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Orders/Ed given\_\_\_\_\_\_\_\_\_\_\_\_ | | **Assessment** | | **Plan** | |