**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** |