Today's Date ___/_____/______ **Last Name/First Name**____________________________ **DOB** ___/______/______

Gender M_____F______ **Race/Ethnicity** _____________________ **Occupation**________________________

Married_______Single_________Divorced______Widowed_____________

Chief Complaint (Reason for your visit)____

Problem ____________________ **When did it start?** ___________ Weeks _______Months _______Years _________

It is always there? Y N **What part of your body?**____

How severe is it? Mild Mod Severe **Have you ever had this problem in the past?** Y N

Does anything help the problem? Y N **If so what?** ____

Does anything make the problem worse? Y N **If so what?** ____

Does the problem interfere with your normal functions? Y N **If Yes, explain** _____________________

Active medical problems (Past History & Surgeries) ____

____

____

____

Family History (Cancer, Colon Polyps, Liver Disease, Colitis, Heart Disease, Stroke, DM; age and cause of death for parents and siblings)

____

____

Medication Allergies (name & reaction) ____________________________ **Other Allergies** _____________________

Medications (Name, Dose/mg, # times per day; include OTC) ____

____

____

____

Do you smoke/did you smoke? Y N # packs per day/ years/quit date ___________________________________
Do you drink alcohol/history of alcohol abuse? Y N # drinks per week ___________________________________

 Reviewed by (MD, Sign & Date) ___________________________________

Constitutional

Recent weight change	No	Yes
Fever	No	Yes
Chills	No	Yes
Fatigue	No	Yes

Eyes

Blurred vision	No	Yes
Glaucoma	No	Yes
Cataracts	No	Yes

Ears/Nose/Throat

Hearing loss	No	Yes
Ringing in ears	No	Yes
Mouth sores	No	Yes

Cardiovascular

Chest pain	No	Yes
Shortness of breath	No	Yes
Swelling of ankles	No	Yes

Respiratory

Chronic cough	No	Yes
Coughing up blood	No	Yes
Wheezing	No	Yes

Genitourinary

Burning with urination	No	Yes
Blood in Urine	No	Yes

Musculoskeletal

Joint pain or swelling	No	Yes
Back pain	No	Yes
Muscle pain	No	Yes

Skin

Rash	No	Yes
Itching	No	Yes

Gyn

Are your pregnant?	No	Yes
Menopause	No	Yes

Last menstrual period (date) _______________

Gastrointestinal

Poor appetite	No	Yes
Difficulty swallowing	No	Yes
Heartburn	No	Yes
Nausea	No	Yes
Vomiting	No	Yes
Bloating	No	Yes
Belching	No	Yes
Regurgitation	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Abdominal pain	No	Yes
Recent change in bowel habits	No	Yes
Rectal bleeding	No	Yes
Black, tarry stools	No	Yes

Neurological

Headaches	No	Yes
Seizures	No	Yes
Strokes	No	Yes
Numbness	No	Yes

Psychiatric

Memory loss	No	Yes
Confusion	No	Yes
Depression	No	Yes
Anxiety	No	Yes
Sleep disturbance	No	Yes

Endocrine

Heat/cold intolerance	No	Yes
Excessive thirst	No	Yes
Excessive urination	No	Yes

Hematological

Bleeding/bruising tendency	No	Yes
Anemia	No	Yes
Transfusions	No	Yes

Advanced Directive? Y N

Living Will? Y N

Pharmacy Name ____________________________

Pharmacy Phone # __________________________________

Pharmacy Fax # ____________________________

 Reviewed by (MD, Sign & Date) ________________________________