Patient Name: _____ Date: _____

Current Medications

Please list all medications you are taking at this time, include vitamins, topicals, injections, supplements & herbals or provide a complete list. (use back if needed.)

Name of Drug	*Dose (include strength and number of pills per day)*	*How long have you taken this medication?*	*Why do you take this medication?*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

PHARMACY _____ (for local prescriptions)

Allergies - Please list all medications and environmental agents you are allergic to. Please include what type of reaction you have (hives, nausea, breathing problems, etc.) and severity.

Past Medical History - Please include all medical problems such as diabetes, hypertension, etc.

Past Surgical History - Please list all procedures including surgeries, colonoscopies, heart catheterizations, etc. Include year completed

Patient Name: _____ Date: _____

Family History: unknown: _____ adopted: _____

Mother ☐ Cancer: type _____ ☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Father ☐ Cancer: type _____ ☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Sister ☐ Cancer: type _____ ☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Brother ☐ Cancer: type _____ ☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Maternal Grandmother ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Maternal Grandfather ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Paternal Grandmother ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Paternal Grandfather ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Maternal Aunts/uncles ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Paternal Aunts/uncles ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐ diabetes
Other _____ ☐ dementia ☐ blood/genetic disorder

Patient Name: _____ Date: _____

Social History

SMOKING/NICOTINE
Do you currently smoke? Yes/No
If Yes: how many years _____
how many cigarettes/packs per day _____
Have you ever smoked? Yes/No
If Yes: When did you quit _____
Do you currently use any other nicotine products such as patches or gum? Yes/No
Have you ever or do you currently use any type of smokeless tobacco? Yes/No
If yes, what type _____
Do you vape or use e cigarretes? Yes/no/never/not currently

ALCOHOL
Do you ever drink alcohol? Yes/No
If Yes: how many drinks/month _____

SEXUAL ACTIVITY:
Are you sexually active: Yes/No Male/female partner
Women: first day of last period _____
If sexually active could you be pregnant and what birth control method do you use?
_____

SUBSTANCE USE
Do you use illegal substances? In the past / currently / never
If Currently What type & How often _____
If in the past What type _____ & When did you quit _____

SOCIOECONOMIC
Are you employed? Yes/No
If Yes: What type of work do you do or title _____

DEMOGRAPHICS
Marital status
Are you: Single Married Legally Separated Divorced Widowed Significant other
Spouse/Significant others Name _____
Number of living Children _____

SOCIAL DOCUMENTATION
Do you participate in any physical activity ? Yes/No
If Yes, what _____
If exercise what type and how often _____
Do you care for any large animals (over 40 pounds)? Yes/no type _____
Do you have to help care for disabled dependents or family members? Yes/no
If Yes, what type of care _____

PRIMARY CARE PHYSICIAN : _____

Patient Name: _____ Date: _____

Review of Systems (symptoms within the last 7 days)

Constitution

Fatigue	YES	NO
Fever	YES	NO
Unexpected Weight Change	YES	NO
Other_____	YES	NO

Ear/Nose/Throat

Congestion	YES	NO
Hearing Loss	YES	NO
Nosebleeds	YES	NO
Sinus Pain	YES	NO
Sore Throat	YES	NO

Eyes

Visual Disturbance	YES	NO

Respiratory

Stop breathing	YES	NO
Cough	YES	NO
Shortness of breath	YES	NO
Wheezing	YES	NO
Other_____	YES	NO

Cardiovascular

Chest Pain	YES	NO
Leg Swelling	YES	NO
Palpitations	YES	NO
Other_____	YES	NO

Gastroenterology

Abdominal Pain	YES	NO
Constipation	YES	NO
Nausea	YES	NO
Vomiting	YES	NO
Other_____	YES	NO

Musculoskeletal

Joint Pain	YES	NO
Back Pain	YES	NO
Difficulty Walking	YES	NO
Joint Swelling	YES	NO
Muscle Pain	YES	NO

Skin

Color Change	YES	NO
Rash	YES	NO
Wound	YES	NO

Immunosuppressed

Immunocompromised	YES	NO
Other_____	YES	NO

Neurological

Dizziness	YES	NO
Facial Asymmetry	YES	NO
Headaches	YES	NO
Light Headedness	YES	NO
Numbness	YES	NO
Seizure	YES	NO
Fainting	YES	NO
Weakness	YES	NO

Hematologic

Bruises easily	YES	NO
Other_____	YES	NO

Psychiatric

Confusion	YES	NO
Dysphoric Mood	YES	NO
Nervous/Anxiety	YES	NO
Suicidal Ideas	YES	NO

Endocrine

Cold Intolerance	YES	NO
Heat Intolerance	YES	NO
Other_____	YES	NO

Urinary/Reproductive

Difficulty Urinating	YES	NO
Painful Urination	YES	NO
Frequent Urination	YES	NO
Blood in Urine	YES	NO
Urgency	YES	NO

Female

Vaginal Bleeding	YES	NO
Vaginal Discharge	YES	NO