Date: ___/___/_____

Why are you seeing the doctor today?

_____

Name of PCP (Primary Care Provider):

_____

Referring doctor:

_____

(Medical Staff Only)
Patient Label

Result of a(n): Car Accident _____ Work Accident _____ Accident _____ Other _____
Date of Onset: _____

Right or left-handed? _____ Current Occupation: _____

Past Illnesses: Please <u>circle</u> illnesses you have had or have now:

Diabetes type I	Diabetes type II	Stomach Ulcers	Epilepsy
Heart Disease	Eye Disease	Head Injury	Migraine
High Blood Pressure	Arthritis	Liver Disease/Hepatitis	Bowel Disease
Immuno-deficiencies	Cancer/type_____	Pneumonia	Alcoholism
Blood Clots	Thyroid Disease	Depression	Tuberculosis
Cortisone Therapy	Rheumatic Fever	Drug Abuse	Asthma
Emphysema/COPD	Kidney Disease	Gallbladder Disease	Stroke
Bleeding Problems	Radiation Tx	Sleep Apnea	Anemia
Osteoporosis	Other: _____		

Past Surgeries/Hospitalizations	**Year**	**Complications**

Are you presently taking anticoagulants?	Yes	No	Describe: _____
Have you ever had general anesthesia?	Yes	No	
Any problems with anesthesia?	Yes	No	Describe: _____
Do you have allergy to Latex?	Yes	No	
Do you have food allergies?	Yes	No	Describe: _____
Pregnant Now (if applicable)	Yes	No	
Allergies/Sensitivities to Medications?	Yes	No	List: _____

_____

_____

List All Medications	**Dose**	**Frequency**	**Doctor**

List any herbal supplements or vitamins you are taking:

_____ _____

_____ _____

(Medical Staff Only)
Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp: _____

Please Circle if You Have:

Crowns Bridges Dentures Partials Loose Teeth

Hearing Aids Contact Lenses Glasses Body Piercing

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Father	A	D	_____	_____
Mother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Child	A	D	_____	_____
Child	A	D	_____	_____
Child	A	D	_____	_____

Social History

Exercise? _____Daily _____Weekly _____Monthly _____Rarely _____Never
What type of exercise? _____
History of substance abuse? ___No ___Yes What? _____
Do you drink alcohol? ___No ___Daily ___1-2 x a wk ___1-2 x a month ___Rarely

Review of Systems

Are you currently having or have you had problems with your:

	Circle	Describe all yes responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Heart (Chest pain, palpitations, murmur)	No Yes	_____
Digestion (Food intolerance, ulcers, pain)	No Yes	_____
Bowels (Constipation, diarrhea, ect.)	No Yes	_____
Bladder (Pain, urgency, frequency, ect,)	No Yes	_____
Appetite, weight gain/loss, weakness	No Yes	_____
Fever, chills, nausea, vomiting	No Yes	_____
Skin (rashes, sores, itching)	No Yes	_____
Excessive thirst	No Yes	_____
Balance, dizziness, numbness, tingling	No Yes	_____
Shortness of breath	No Yes	_____
Other	No Yes	_____

We are required to ask the following question:

What is your Preferred Language: _____

Race:
o White
o American Indian or Alaska Native
o Asian
o Black or African American
o Native Hawaiian or Other Pacific Island
o Unknown o Other _____

Ethnicity:
o Hispanic Origin o Non-Hispanic Origin o Unknown

Smoking Status:
___Never smoked

___Current every day
Date/year you became a current every day smoker: _____
Packs Per Day: _____
___Current some days
Date/year you became a current some day smoker: _____
Packs Per Day: _____
___ Former smoker
Date/year you started smoking: _____
Date/year you quit smoking: _____
___ Smokeless tobacco or any other form of nicotine
___ Never Used
____ Current User
____ Former User Quit date: _____

Vaping YES OR NO

Have you received the 2019/2020 Flu Vaccine?

☐ Yes- When_____

☐ No- Do you plan to get it? ☐Yes ☐No

For patients over 65 years old:
Have you received the Pneumococcal Vaccine?

☐ Yes- When_____

☐ No- Do you plan to get it? ☐Yes ☐No

Patient Signature _____ Date _____

Reviewed by _____ Date _____