|  |  |  |
| --- | --- | --- |
| Patient Name:  |  | Age: |
| Date: |  | SS Number: |
| Phone Number: |  | Email:  |
| Address: |  |  |
| City/State/Zip: |  |  |
| Date of Birth: |  |  |

**Medical History:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Y | N |  | Y  | N |  | Y | N |  |
| \_ | \_ | Diabetes | \_ | \_ | Depression | \_ | \_ | Lung Disorder |
| \_ | \_ | High Blood Pressure | \_ | \_ | Psychiatric disorder | \_ | \_ | HIV/AIDS |
| \_ | \_ | Heart Attack | \_ | \_ | High Cholesterol/triglycerides | \_ | \_ | Stroke |
| \_ | \_ | Hypothyroidism | \_ | \_ | Bleeding tendency | \_ | \_ | Hepatitis |
| \_ | \_ | Kidney Stone | \_ | \_ | GI disorder | \_ | \_ | Cancer |
| \_ | \_ | Heart disease | \_ | \_ | History of motion sickness | \_ | \_ | Asthma |
| \_ | \_ | Rheumatic fever | \_ | \_ | Pulmonary Embolism | \_ | \_ | DVT |
| \_ | \_ | History of anesthesia Problems | \_ | \_ | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Past Surgical History:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Y | N |  | Year | Y | N |  | Year |
| \_ | \_ | Appendectomy | \_\_\_\_ | \_ | \_ | Hernia Repair | \_\_\_\_ |
| \_ | \_ | Hysterectomy | \_\_\_\_ | \_ | \_ | Oophorectomy | \_\_\_\_ |
| \_ | \_ | Tonsillectomy | \_\_\_\_ | \_ | \_ | Heart Bypass | \_\_\_\_ |
| \_ | \_ | Cosmetic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_ | \_ | \_ | Gallbladder Removal | \_\_\_\_ |
| \_ | \_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \*please list any other surgical proc\* |  |

Do you or have you ever used tobacco? (Circle one) **Yes No**

If yes, what form? (Cigarette, Chewing Tobacco, Cigar, Pipe, Vapor Pen) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have smoked \_\_\_\_ pack(s) per day for \_\_\_\_\_ years. I quit smoking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

Do you use alcohol? (Circle one) **Yes No** Drinks per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any recreational drugs? (Circle one) **Yes No**

If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your immunizations current?(Circle one) **Yes No**

Do you have an Advanced Directive? (Circle one) **Yes No**

If yes, please provide a copy to our office.

Occupation:

**Family Health History:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Y | N |  |  | Circle |  |
| \_ | \_ | High blood pressure |  | Paternal | Maternal |
| \_ | \_ | Heart Disease |  | Paternal | Maternal |
| \_ | \_ | Stroke |  | Paternal | Maternal |
| \_ | \_ | Breast cancer | Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Paternal | Maternal |
| \_ | \_ | Other cancer | Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Paternal | Maternal |
| \_ | \_ | Other illness | Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Paternal | Maternal |
|  |  |  |  |  |  |

**Review of Symptoms**

Please check **circle** any of the following symptoms that you have had within the last **2 weeks:**

Abdomen swelling

Ankle swelling

Anxious

Back Pain

Blood in Stool

Breast Pain

Bruising

Chest Pain

Chills

Cold Intolerance

Constipation

Cough

Cysts

Depressed

Diarrhea

Dizziness

Ear Pain

Eye discharge

Eye Pain

Fainting

Fever

Gland Swelling

Growing Lesions

Hallucinations

Headaches

Head Intolerance

Itching

Irregular Breathing

Joint Pain

Labored Breathing

Nasal Congestion

Nausea

Neck Pain

Nipple Discharge

Numbness

Pain in Flank

Pain – testicles

Heart Palpitations

Rash

Scabbing Wound

Seizures

Skin Lesion, Irregular

Sore Throat

Sputum

Suicidal Thoughts

Swelling

Thirst, Excessive

Tired

Urination, Excessive

Vomiting

Weakness

Weight Loss

Wheezing

Wound, Non-healing

**BREAST HISTORY**

Last mammogram date:\_\_\_\_\_\_\_\_\_\_\_\_\_ **Location**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had** an abnormal mammogram OR breast biopsy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you perform self-breast exams? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Children:\_\_\_\_\_\_\_\_\_\_\_\_ Have you successfully breast fed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What size of bra do you wear currently?\_\_\_\_\_\_\_\_\_\_

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Y | N |  |  | Y | N |  |  | Y | N |  |
| \_ | \_ | Blood Thinner |  | \_ | \_ | High blood pressure meds |  | \_ | \_ | Diet Pills |
| \_ | \_ | Heart Medication |  | \_ | \_ | Diuretics (Water Pills) |  | \_ | \_ | Aspirin |
| **Do you (or have you ever) taken:** |
| Y | N |  |  | Y | N |  |  | Y | N |  |
| \_ | \_ | Steroids (cortisone) |  | \_ | \_ | Immunosuppressants |  | \_ | \_ | Vitamin E |
| \_ | \_ | Herbal supplements |  | \_ | \_ | Chemotherapy |  |  |  |  |
| **Are you allergic to:** |
| Y | N |  |  | Y | N |  |  | Y | N |  |
| \_ | \_ | Penicillin |  | \_ | \_ | Novocain |  | \_ | \_ | Latex |
| \_ | \_ | Other drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |
| \_ | \_ | Other allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |

|  |  |
| --- | --- |
| **List medications** | **Strength/Dose** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Pharmacy:** | **Phone:** |
| **Address:** |  |
|  |  |

**Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Physician’s Name and Phone Number:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last PCP Appointment:\_\_\_\_\_\_\_\_\_\_ Last EKG:\_\_\_\_\_\_\_\_\_\_ Last Blood Draw:\_\_\_\_\_\_\_\_\_\_**

How did you hear about us? (Word of Mouth, Internet Search, Facebook, Doctor Referral, Other)

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

|  |
| --- |
| **Nurse use only:** |
| Temp\_\_\_\_\_ | BP\_\_\_\_\_ | HR\_\_\_\_\_ | RR\_\_\_\_\_ | Height\_\_\_\_\_ | Weight\_\_\_\_\_ |  |