



PATIENT HISTORY

Name _____ Date of Birth _____ Social Security _____

Occupation _____ Education (# of years completed) _____

Do you have any financial concerns about your healthcare? No Yes _____

ADVERSE REACTIONS

Drugs (Please Specify)

Foods (Please Specify)

_____	Reaction _____	_____	Reaction _____
_____	Reaction _____	_____	Reaction _____
_____	Reaction _____	_____	Reaction _____
_____	Reaction _____	_____	Reaction _____
<input type="checkbox"/> Iodine / Shellfish	Reaction _____	<input type="checkbox"/> Bee Stings/Insect Bites	Reaction _____
<input type="checkbox"/> Latex	Reaction _____	<input type="checkbox"/> Adhesive Tape	Reaction _____

CURRENT MEDICATIONS

Please include over-the-counter medications

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATIONS

Please Indicate Date of Last Injection

<input type="checkbox"/> Pneumonia _____	<input type="checkbox"/> Diphtheria _____	<input type="checkbox"/> Pertussis _____
<input type="checkbox"/> MMR _____	<input type="checkbox"/> Polio _____	<input type="checkbox"/> Tetanus _____
<input type="checkbox"/> Flu _____	<input type="checkbox"/> Hepatitis A _____	<input type="checkbox"/> Hepatitis B _____
<input type="checkbox"/> TB Test _____	<input type="checkbox"/> Varivax _____	

HOSPITALIZATION OR SURGERY

DATES / REASON

DATES / REASON

_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY (check all that apply)

<input type="checkbox"/> Headaches	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Menstrual Dysfunction
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Stroke	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Gout	<input type="checkbox"/> Depression
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Allergies / Hay Fever	<input type="checkbox"/> Bowel Irregularity	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Chest Pain / Angina	<input type="checkbox"/> Asthma	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Dizziness / Fainting
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prostate Disease
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Sexual Dysfunction	<input type="checkbox"/> Anemia	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Previous Blood Transfusion	<input type="checkbox"/> Bladder Dysfunction
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Positive TB Screening	<input type="checkbox"/> Aids / HIV	<input type="checkbox"/> Cancer (type): _____
	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Other: _____

FAMILY HISTORY

Has any blood relative had any of the following? Check all that apply and list which family member.

<input type="checkbox"/> Alzheimer's Disease _____	<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Bleeding Tendency _____
<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> Mental Health Disorder _____
<input type="checkbox"/> Memory Loss _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Osteoporosis _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Stroke / CVA _____	<input type="checkbox"/> Cancer (type) _____	<input type="checkbox"/> Hearing Loss _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Neurological Disorder _____		<input type="checkbox"/> Tuberculosis _____	

FUNCTIONAL ASSESSMENT

What is the easiest way for you to learn new things? Reading Listening Pictures Demonstration Video
Do you have any difficulty with reading or writing? No Yes (explain): _____
Do you have any problems with: Vision Hearing Speech Walking Lifting
Do you have any religious or cultural beliefs/values we should be aware of as we provide your care? No Yes (explain): _____

Are you experiencing any stress/stressful situations? No Yes (explain): _____

Have you experienced any traumatic or abusive situations? No Yes (explain): _____

Do you live alone? No Yes Who is your Caregiver? _____

NUTRITIONAL ASSESSMENT

Without trying, have you gained/lost 10 pounds or more in the last six months? No Yes

Are you worried about a possible eating disorder? No Yes

Do you avoid or not eat meat, dairy products, or fruits/vegetables? No Yes

Do you take any herbal, vitamin/mineral, or nutritional drinks or supplements? No Yes

HABITS (check all that apply)

Smoke (if yes): Packs Daily _____ Stopped When: _____ Other Tobacco Products _____
 Coffee or other Caffeinated Drinks (if yes): How many daily _____ Diet: Salt Intake _____
 Exercise Routine (if yes): _____ Type: _____ Snoring _____
 Difficulty Falling Asleep _____ Special Diet _____
 Contact with Blood/Body Fluid at Work: _____ HIV Exposure/Risk _____
 Recreational/Street Drug Use (specify): _____ Seat Belts _____
 Alcohol (if yes): Type: _____ Amount: _____ Daily Weekly Socially

MEN ONLY

Date of last rectal exam: _____ Date of last PSA: _____
Sexually active: No Yes Monthly Testicular self exam: No Yes
Practice safe sex: No Yes

WOMEN ONLY

Last menstrual period: _____ Sexually active Yes No
Age at onset: _____ Regular Irregular Practice safe sex Yes No
Flow: Heavy Moderate Light Pain/Bleeding after sex Yes No
Pain/Cramps with menses: Yes No Pregnant Yes No
Days of flow: _____ Planning Pregnancy Yes No
Length of cycle: _____ Number of Pregnancies: _____
Last pap smear: _____ Number of live births: _____
Last Mammogram: _____ Number of miscarriages: _____
Monthly self breast exam: Yes No Birth control method: _____
Flushing/menopause: Yes No Name of birth control if using: _____

OTHER DOCTORS

SIGNATURE

Please list all of the other doctors that you are currently seeing.

Name / Specialty	Reason	Signature of person completing form
_____	_____	_____ date
_____	_____	Relationship: _____
_____	_____	(if other than patient)

This section to be completed by Provider
To be reviewed every three (3) years or as health status changes.

Date Reviewed: _____ Provider Initials: _____ Date Reviewed: _____ Provider Initials: _____
Date Reviewed: _____ Provider initials: _____ Date Reviewed: _____ Provider Initials: _____