

Today's Date _____ Patient Name _____ Age _____

Birthdate _____ Date of last physical exam _____ Doctor _____

Pharmacy: _____ Durable Medical Equipment Co _____

Specialists _____

Health History

Past Medical/Surgical history Have you had? (mark box <input checked="" type="checkbox"/>)	Review of Systems Do you have? (mark box <input checked="" type="checkbox"/>)	
<input type="checkbox"/> Heart Trouble <input type="checkbox"/> MI/Heart Attack <input type="checkbox"/> Angina/chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Blood pressure problems <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis, emphysema <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Liver problems <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Arthritis, joint or back pain <input type="checkbox"/> Stroke (What weakness do you have from the stroke?? _____ <input type="checkbox"/> Kidney problems <input type="checkbox"/> Alzheimer's, other brain disease <input type="checkbox"/> History of cancer Type: _____ Type: _____ <input type="checkbox"/> HIV positive or AIDS <input type="checkbox"/> Other: _____	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever, chills <input type="checkbox"/> Weakness, fatigue or tiredness <input type="checkbox"/> Blurred vision, eye discharge <input type="checkbox"/> Earache or ear discharge <input type="checkbox"/> Sore throat or oral lesions <input type="checkbox"/> Stuffy nose or post nasal drip <input type="checkbox"/> Cough/sputum production <input type="checkbox"/> Heartburn <input type="checkbox"/> Constipation or Diarrhea <input type="checkbox"/> Bloody/tarry stools <input type="checkbox"/> Stomach pain <input type="checkbox"/> Difficulty controlling urine <input type="checkbox"/> Blood in urine <input type="checkbox"/> Sexual problems <input type="checkbox"/> Joint pains <input type="checkbox"/> Back pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hair loss <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> CPAP	<input type="checkbox"/> Skin rash <input type="checkbox"/> Itching <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swelling of legs <input type="checkbox"/> Breast lump or discharge <input type="checkbox"/> Anemia <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Headache <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Memory Loss <input type="checkbox"/> Frequent falls <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Snoring at night <input type="checkbox"/> Daytime sleepiness <input type="checkbox"/> Hearing problems: <input type="checkbox"/> Other problems: _____

List Previous Biopsies, Endoscopies and Surgeries (Type and Date)

1.
2.
3.
4.
5.
6.
7.

Date of Last:

Pap:	Mammogram:	Bone Density:
PSA:	Colonoscopy:	Complete Bloodwork:

Occupation (if retired, occupation before retirement):	
Education Level:	Difficulty Reading? <input type="checkbox"/> Yes <input type="checkbox"/> No

Social History - Do you?			
<input type="checkbox"/> Smoke	# packs per day:	# years:	<input type="checkbox"/> Quit When did you quit?
<input type="checkbox"/> Drink alcohol	# drinks per day/week	<input type="checkbox"/> Recreational drug use	
<input type="checkbox"/> Victim of abuse/neglect			

Family History				
Relative	Age (if living)	Age/Year of Death	Current Illness	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
Children				

Current Medications		
Drug name	Dose	Time of day taken

Medication Allergies <input type="checkbox"/> None	Vaccines
Include Drug Name and Reaction	Flu: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Pneumonia: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Shingles: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Tetanus: <input type="checkbox"/> No <input type="checkbox"/> Yes Date:
	Other:
Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Name: _____ Date of Birth: _____