

Please complete and return this form along with your patient registration forms, a copy of your insurance cards and I.D., and a list of your medicines. Please fill in the medicine list we gave you with this form or give us your own list of all prescription and over-the-counter medicines you take. Include medication strength and how often you take it. We will gladly schedule your appointment after all paperwork has been submitted.

First Name _____ Last Name _____ Date of Birth _____ Today's Date _____

REASON FOR THIS VISIT _____

PAST ILLNESS: Indicate if you have or ever had: high blood pressure I10 diabetes E11.9 or E11.65 high cholesterol E78.0 osteoarthritis M15.0 asthma J45.909

COPD J44.9 angina I20.9 blocked arteries in heart I25.10 heart attack I25.2, when? _____ stroke I63.50, 286.73, when? _____ atrial fibrillation I48.91
cancer , what kind(s)? _____ underactive thyroid E03.9 osteoporosis M81.0 other major illness _____

ALLERGIES: Please indicate if you have been allergic to or had a bad reaction to the following: no allergies penicillin sulfa
codeine aspirin iodine latex (rubber) flu shots other allergies _____

TOBACCO USE: Please indicate if you never smoked smoke _____ Packs a day have quit smoking when? _____

ALCOHOL USE: non-drinker occasional light social more than 2 drinks per day beer wine hard liquor

SURGERIES: Please indicate if you have had hysterectomy both ovaries out appendix out tonsils out gallbladder out
prostate out open heart for bypass when? _____ other operations _____

FAMILY HISTORY: Please check if your mother, father, sisters, brothers or children have had: heart attack diabetes asthma
high blood pressure high cholesterol thyroid disease hardening of the arteries severe arthritis stroke
cancer (what kinds?) _____ other major illness _____

SOCIAL HISTORY: married single widowed divorced retired employed line of work _____

REVIEW OF SYSTEMS: Please answer the following questions and indicate if you have recently had any of the following symptoms. If you have other symptoms not relating to your main problem or which require less urgent attention we can schedule you to return to address these in the near future.

GENERAL: fever chills poor appetite tiredness weight loss without trying weight gain heavy sweating

HEAD/EYE/EAR/NOSE/THROAT: frequent headaches eye pain vision problems earache hearing loss sinus problems

runny or stuffy nose frequent sore throats hoarseness other _____

LUNGS: short of breath at rest short of breath with exercise chest hurts when taking a deep breath wheeze dry cough
cough up blood cough up mucus if so, what color? _____ loud snoring other _____

HEART/CIRCULATION: chest pain, pressure, or tightness short of breath when lying flat swelling of ankles heart murmur
dizzy spells palpitations (fluttering or racing of heart) calf of leg hurts when walking fainting spell when? _____

INTESTINES: nausea vomiting diarrhea constipation pain in the stomach area heartburn indigestion
blood in bowel movements black bowel movements trouble swallowing What year was your last Colonoscopy? _____

URINARY TRACT: pain or burning with urination blood in the urine loss of bladder control have to strain to pass urine
get up at night to urinate 1-2 times 3 or more times loss of sexual ability **MEN ONLY:** lump in testicle discharge from penis

NERVOUS SYSTEM/EMOTIONAL: numbness or tingling temporary loss of vision double vision memory loss nervousness
weakness of arm or leg slurring or loss of speech feel depressed trouble sleeping mood swings lack of sexual desire

ENDOCRINE: excessive thirst dry mouth urinate excessively large amounts unusually sensitive to cold or heat

PREVENTIVE: What year was your: Prevnar 13 (new vaccine available since 2012) pneumonia shot _____ Pneumovax 23 pneumonia shot _____

Last flu shot _____ shingles vaccine _____ Last tetanus shot _____ Most recent EKG _____ Last Medicare Wellness Exam _____

LADIES ONLY: discharge from vagina vaginal dryness hot flashes heavy periods When was you last period? _____

Date of last mammogram _____ Date of last pap smear _____ Date of last scan for osteoporosis _____