

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**ALLERGIES**  NO ALLERGIES

ALLERGY	ALLERGIC REACTION

**MEDICATIONS**  NO MEDICATIONS

MEDICATION <i>(please list all)</i>	DOSE <i>(mg., pill, etc.)</i>	TIMES PER DAY

*If you need more room to list medications, please write them on a blank sheet of paper with the required information.*

**HEALTH MAINTENANCE SCREENING TEST HISTORY**

<b>Cholesterol</b>	Date:	Facility/Provider:	Abnormal result? Y N
<b>Colonoscopy/Sigmoid</b>	Date:	Facility/Provider:	Abnormal result? Y N
<b>Mammogram</b>	Date:	Facility/Provider:	Abnormal result? Y N
<b>Pap Smear</b>	Date:	Facility/Provider:	Abnormal result? Y N
<b>Bone Density</b>	Date:	Facility/Provider:	Abnormal result? Y N

**VACCINATION HISTORY**

Last Tetanus Booster or TdaP:	Last Pnuemovax <i>(Pneumonia)</i> :
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine <i>(Shingles)</i> :	

### PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer ( <i>type: _____</i> )			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes ( <i>type: _____</i> )			
Emphysema ( <i>COPD</i> )			
Heart Disease			
High Blood Pressure ( <i>Hypertension</i> )			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal ( <i>Kidney</i> ) Disease			
Migraine Headaches			
Stroke			
Other: _____			
Other: _____			

### SURGERIES

TYPE ( <i>specify left/right</i> )	DATE	LOCATION/FACILITY

### WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

**FAMILY MEDICAL HISTORY**     NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✓ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type: _____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other: _____	Other: _____	Other: _____
	Mother																	
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
_____																		

**SOCIAL HISTORY**

Occupation (or prior occupation):	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> LOA <input type="checkbox"/> Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift?    Y    N    N/A	
Marital Status (check one): <input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____	
Do you have children?    Y    N    If yes, how many? _____	

**OTHER HEALTH ISSUES**

<b>TOBACCO USE</b>	Do you smoke cigarettes?    Y    N <i>If you have never smoked, please continue to Alcohol/Drug Use.</i>	
Current: Packs/day _____ # of Years _____	Past: Quit Date _____ Packs/day _____ # of Years _____	
Other Tobacco (check one): <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew		
<b>ALCOHOL/DRUG USE</b>	Do you drink alcohol?    Y    N <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor    # of Drinks/week _____	
Do you use marijuana or recreational drugs?    Y    N	Have you ever used needles to inject drugs?    Y    N	
Have you ever taken someone else's drugs?    Y    N		

**OTHER HEALTH ISSUES** CONTINUED

<b>SEXUAL HISTORY</b>	Sexually involved currently? <b>Y</b> <b>N</b> <i>If no sexual history, please continue to Exercise.</i>	
Sexual partner(s) is/are/have been: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Birth Control Method: <input type="checkbox"/> None <input type="checkbox"/> Condom <input type="checkbox"/> Pill/Ring/Patch/Inj/IUD <input type="checkbox"/> Vasectomy		
<b>EXERCISE</b>	Do you exercise regularly? <b>Y</b> <b>N</b> <i>If you answered no, please continue to Sleep.</i>	
What type of exercise?		Duration: How long (min) _____ How often _____
<b>SLEEP</b>	How many hours, on average, do you sleep at night (or during the day, if working night shift)? _____	
<b>DIET</b>	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Would you like advice on your diet? <b>Y</b> <b>N</b>
<b>SAFETY</b>	Do you use a bike helmet? <b>Y</b> <b>N</b>	Do you seat belts consistently? <b>Y</b> <b>N</b>
Working smoke detector in home? <b>Y</b> <b>N</b>		If you have guns at home, are they locked up? <b>Y</b> <b>N</b>
Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Order for Life Sustaining Therapy (POLST)? <b>Y</b> <b>N</b>		
Is violence at home a concern for you? <b>Y</b> <b>N</b>		

**OTHER PROVIDERS/SPECIALISTS**

SPECIALIST	NAME	LAST VISIT
Cardiologist		
Gastroenterologist (GI)		
OB/GYN		
Neurologist		
Pulmonary		
Other: _____		
Other: _____		

**ADDITIONAL INFORMATION**

Have you traveled outside of the country in the last 30 days? <b>Y</b> <b>N</b> If yes, where? _____
Have you served in the military? <b>Y</b> <b>N</b> If yes, how long and what branch? _____
Were you deployed? <b>Y</b> <b>N</b> If yes, where? _____

### OTHER PROVIDERS/SPECIALISTS

<b>CONSTITUTION</b>	<b>CARDIOVASCULAR</b>	<b>SKIN</b>
<input type="checkbox"/> Activity Change	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Color Change
<input type="checkbox"/> Appetite Change	<input type="checkbox"/> Leg Swelling	<input type="checkbox"/> Pallor
<input type="checkbox"/> Chills	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Rash
<input type="checkbox"/> Diaphoresis	<b>GASTROINTESTINAL</b>	<input type="checkbox"/> Wound
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Abdominal Distention	<b>ALLERGY/IMMUNO</b>
<input type="checkbox"/> Fever	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Environmental Allergies
<input type="checkbox"/> Unexpected Weight Change	<input type="checkbox"/> Anal Bleeding	<input type="checkbox"/> Food Allergies
<b>HEAD, EAR, NOSE, THROAT</b>	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Immunocompromised
<input type="checkbox"/> Congestion	<input type="checkbox"/> Constipation	<b>NEUROLOGICAL</b>
<input type="checkbox"/> Dental Problem	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Drooling	<input type="checkbox"/> Nausea	<input type="checkbox"/> Facial Asymmetry
<input type="checkbox"/> Ear Discharge	<input type="checkbox"/> Rectal Pain	<input type="checkbox"/> Headaches
<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Light-headedness
<input type="checkbox"/> Facial Swelling	<b>ENDOCRINE</b>	<input type="checkbox"/> Numbness
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Seizures
<input type="checkbox"/> Mouth Sores	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Speech Difficulty
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Polydipsia	<input type="checkbox"/> Syncope
<input type="checkbox"/> Postnasal Drip	<input type="checkbox"/> Polyphagia	<input type="checkbox"/> Tremors
<input type="checkbox"/> Rhinorrhea	<input type="checkbox"/> Polyuria	<input type="checkbox"/> Weakness
<input type="checkbox"/> Sinus Pressure	<b>GENITOURINARY</b>	<b>HEMATOLOGIC</b>
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Difficulty Urinating	<input type="checkbox"/> Adenopathy
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Bruises/Bleeds Easily
<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Enuresis	<b>PSYCHIATRIC</b>
<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Flank Pain	<input type="checkbox"/> Agitation
<input type="checkbox"/> Voice Change	<input type="checkbox"/> Frequency	<input type="checkbox"/> Behavior Problem
<b>EYES</b>	<input type="checkbox"/> Genital Sore	<input type="checkbox"/> Confusion
<input type="checkbox"/> Eye Discharge	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Decreased Concentration
<input type="checkbox"/> Eye Itching	<input type="checkbox"/> Penile Discharge	<input type="checkbox"/> Dysphoric Mood
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Penile Pain	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Eye Redness	<input type="checkbox"/> Penile Swelling	<input type="checkbox"/> Hyperactive
<input type="checkbox"/> Photophobia	<input type="checkbox"/> Scrotal Swelling	<input type="checkbox"/> Nervous/Anxious
<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Testicular Pain	<input type="checkbox"/> Self-injury
<b>RESPIRATORY</b>	<input type="checkbox"/> Urgency	<input type="checkbox"/> Sleep Disturbance
<input type="checkbox"/> Apnea	<input type="checkbox"/> Urine Decreased	<input type="checkbox"/> Suicidal Ideas
<input type="checkbox"/> Chest Tightness	<b>MUSCULAR</b>	
<input type="checkbox"/> Choking	<input type="checkbox"/> Arthralgias	
<input type="checkbox"/> Cough	<input type="checkbox"/> Back pain	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Gait Problems	
<input type="checkbox"/> Stridor	<input type="checkbox"/> Joint Swelling	
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Myalgias	
	<input type="checkbox"/> Neck Pain	
	<input type="checkbox"/> Neck Stiffness	