

Patient Name _____

Date _____

DOB _____

Height _____

Weight _____

REASON FOR VISIT

Why are you seeing the doctor today? _____

 Have you been treated for this problem in the past? ☐ Yes ☐ No

If yes, please explain _____

 Have you had any recent radiology or laboratory studies? ☐ Yes ☐ No

 If yes, please indicate **where**, **when**, and **type** of study _____

In an effort to help us keep track of your important vaccinations and health screenings, we collect the following information in order to deliver the best healthcare.

Date of Last Tetanus Shot ____/____/____

 Type : ☐ Tdap ☐ TD

 Location: ☐ Physician Office ☐ Place of Work ☐ Other

Date of Last Pneumococcal Vaccine ____/____/____

 Type : ☐ Prevnar ☐ Pneumovax

 Location: ☐ Physician Office ☐ Place of Work ☐ Other

Date of Last Influenza Shot ____/____/____

 Location: ☐ Physician Office ☐ Place of Work ☐ Other

Date of Last Mammogram ____/____/____

Date of Last Colonoscopy ____/____/____

Date of Last Pap Smear ____/____/____

MEDICAL HISTORY

Please indicate if you have received treatment for the conditions below, or if you are currently receiving treatment.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Alzheimer's	☐	☐	Gallbladder Problems	☐	☐	Obesity	☐	☐	Thyroid
☐	☐	Anemia	☐	☐	Gout	☐	☐	Osteoporosis	☐	☐	Ulcer
☐	☐	Arthritis	☐	☐	Heart Disease/Heart Attack	☐	☐	Phlebitis			
☐	☐	Asthma	☐	☐	Hepatitis	☐	☐	Peripheral Vascular Disease			
☐	☐	Attention Deficit Disorder	☐	☐	HIV/AIDS	☐	☐	Polio			
☐	☐	Birth Defects	☐	☐	High Blood Pressure	☐	☐	Psychological Problems			
☐	☐	Bladder Problems	☐	☐	High Cholesterol	☐	☐	Pulmonary Embolism			
☐	☐	Bleeding or Bruising	☐	☐	Intestinal/Bowel Problems	☐	☐	Rheumatoid Arthritis			
☐	☐	Cancer Type _____	☐	☐	Kidney Problems	☐	☐	Sexually Transmitted Disease			
☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	VRE/MRSA/Staph Infection			
☐	☐	DVT/Blood Clots	☐	☐	Lung Problems	☐	☐	Stroke/TIA			
☐	☐	Epilepsy	☐	☐	Migraine	☐	☐	Tuberculosis			

Are there any other medical problems that we should be aware of? _____

 Do you exercise or participate in sports? ☐ Yes ☐ No Type and frequency: _____

 Are you currently pregnant or could you possibly be pregnant? ☐ Yes ☐ No **Date of Last Menstrual Period** ____/____/____

MEDICATIONS

Please list the medications that you are currently taking (including herbal supplements). Please include those with and without a prescription.

Medication	Dose	Frequency	Reason for taking medication

ALLERGY

Please list any present or past allergies (including medication, food, metal, or environmental).

Allergy	Reaction	How reaction was/is treated

SURGERIES AND/OR HOSPITALIZATIONS

Type of Surgery/Reason for Hospitalization	Date	Hospital Name/Surgical Center

☐ I have not had any surgeries or been hospitalized

FAMILY HISTORY

Please indicate if your mother, father, grandparents, brothers, or sisters have been treated or are currently receiving treatment for the conditions listed below and indicate which family member.

Condition	Family Member	Condition	Family Member	Condition	Family Member
☐ Alzheimer's	_____	☐ Heart Disease	_____	☐ Stroke	_____
☐ Cancer	_____	☐ Hypertension	_____	☐ Sudden Death	_____
☐ Diabetes	_____	☐ Osteoporosis	_____	☐ Thyroid	_____
☐ Gout	_____	☐ Rheumatoid Arthritis	_____	☐ Other	_____

SOCIAL HISTORY

Do you use tobacco products? ☐ Yes ☐ No ☐ Former

If Yes/Former: Number _____ Packs per day for _____ years. Type of Tobacco: _____

Do you consume alcoholic beverages? ☐ Yes ☐ No Amount and frequency: _____

Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: _____

Other _____

Patient Name	Date
Signature of Patient / Guardian	Date
Name of Guardian	Date

FOR OFFICE USE

Reviewed By	Date
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