**Today’s date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name [print]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social History:**Education Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (Circle One): Single Married Divorced Widowed

Average per day:
 Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tobacco (Packs Per Day) \_\_\_\_\_\_\_ Years \_\_\_\_\_\_\_\_
 Caffeine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recreational Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Diet (Circle One): Diabetic Low Fat Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

|  |  |  |
| --- | --- | --- |
| **Medications** | **Diagnosis/ Reason for medication** | **Specialist/prescriber?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Implanted medical devices, or other medical devices ie CPAP, Oxygen:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Hospitalizations & Illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies (Medications, Food, Environmental) AND description of reaction:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccines** | **Year** | **Screenings** | **Year** | **Other Tests** | **Year** |
|  |  |  |  |  |  |
| Flu  |  | Colonoscopy |  | DEXA Scan |  |
| Tetanus (Tdap) |  | Mammogram |  | Stress Test |  |
| Pneumonia |  | Pap Smear |  | Other: |  |
| Shingles |  | Eye Exam |  |  |

For Women:
Age of first period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First day of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
# of Pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:**

|  |  |  |
| --- | --- | --- |
| **Surgery** | **Year** | **Specialist** |
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**Family History:**

|  |  |  |
| --- | --- | --- |
| **Diagnosis** | **Relative** (Specify Paternal or Maternal) | **Age at Diagnosis** |
| **Cardiac** (heart attack, stroke, etc) |  |  |
| **High Blood Pressure** |  |  |
| **Cancer** (specify type) |  |  |
| **Diabetes** |  |  |
| **Mental Health** |  |  |
| **Other** |  |  |
|  |  |  |

**Have you had any of the following issues IN THE LAST 3 MONTHS?**

**Systemic:** weight change, fevers, fatigue, etc
**Head:** headache, sinus pain, etc
**Eyes:** vision change, redness, pain, etc
**Neck:** pain, muscle tightness, lumps, etc
**Breast:** lumps, pain, skin change, etc
**Neurological:** dizziness, fainting, confusion, numbness or tingling, etc
**Musculoskeletal:** muscle aches, joint pain, weakness, etc
**Hematological:** bruising, easy bleeding, anemia, etc
**Psychological:** depression, anxiety, trouble sleeping, etc
**Genitourinary:** change in urine, incontinence, genital discharge, etc
**Gastrointestinal:** vomiting, diarrhea, constipation, blood in stool, stomach pain, etc
**Cardiovascular:** chest pain, racing heart, fainting, palpitations, etc
**Pulmonary:** shortness of breath, wheezing, cough, etc
**Ears/Nose/Throat:** sore throat, stuffy nose, snoring, sneezing, etc
**Endocrine:** excessive thirst, hair loss, excessive sweating, etc
**Skin:** rash, itching, sores, etc

**Any concerns you would like to discuss with provider? We may not be able to address all concerns at first visit.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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