Welcome to Our Practice

Patient Name:_____ **DOB:**_____ **Date:**_____

Primary Care Physician:_____ **Chief Complaint:**_____

History of Present Illness

Location_____
(Where is the pain/problem?)

Quality_____
(Ex: normal versus abnormal color activity, etc.)

Severity_____
(How severe is the pain, on a scale of 1-10, 10 being most severe)

Duration_____
(How long have you had this problem, or when did it begin?)

Timing_____
(Does the pain/problem occur at specific times)

Context_____
(Where were you at the onset of this pain/problem?)

Patient Medical History

AIDS	☐ No ☐ Yes	**Glaucoma**	☐ No ☐ Yes	**Infectious Mono**	☐ No ☐ Yes	**Rheumatic Fever**	☐ No ☐ Yes
Arthritis	☐ No ☐ Yes	**Heart Disease**	☐ No ☐ Yes	**Kidney Disease**	☐ No ☐ Yes	**Scarlet Fever**	☐ No ☐ Yes
Bladder infections	☐ No ☐ Yes	**Hemorrhoids**	☐ No ☐ Yes	**Low B/P**	☐ No ☐ Yes	**Smallpox**	☐ No ☐ Yes
Bronchitis	☐ No ☐ Yes	**Hepatitis**	☐ No ☐ Yes	**Migraine Headache**	☐ No ☐ Yes	**Stroke**	☐ No ☐ Yes
Cancer	☐ No ☐ Yes	**Hernia**	☐ No ☐ Yes	**Persistent Cough**	☐ No ☐ Yes	**Thyroid Disease**	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	**High B/P**	☐ No ☐ Yes	**Pneumonia**	☐ No ☐ Yes	**Tuberculosis**	☐ No ☐ Yes
Diptheria	☐ No ☐ Yes	**HIV**	☐ No ☐ Yes	**Polio**	☐ No ☐ Yes	**Ulcers**	☐ No ☐ Yes
Epilepsy	☐ No ☐ Yes	**Hives or Eczema**	☐ No ☐ Yes	**Date of last chest xray**_____		**Whooping Cough**	☐ No ☐ Yes

Are you currently pregnant ☐ No ☐ Yes

Patient Social History

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Race: ☐ Caucasian/White ☐ African American ☐ Asian/Pacific Islander ☐ Native Hawaiian ☐ Native American Indian/Eskimo

☐ Other_____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Language: ☐ English ☐ French ☐ Spanish ☐ Russian ☐ Italian ☐ German ☐ Japanese ☐ Bangla ☐ Other_____

Occupation:_____

Work Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Disabled, list disability start date_____

Hand Dominance: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Previously, but quit on_____ ☐ Current packs/day_____

Use of Street Drugs: ☐ Never ☐ Type/frequency_____

Family Medical History

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____

Patient Name:_____ **DOB:**_____

Past Medical History

Previous Hospitalizations, Surgeries or Serious Illnesses **When** **Hospital, City, State**

Medications (Include Nonpresciption)

Pharmacy Name:_____ **Pharmacy Phone Number:**_____

Name **Strength** **Dosage** **How Often** **Date Started**

Allergic/Immunologic: Please list:

History of skin reaction or other adverse reaction to:

Medication **Reaction** **Date of Reaction**

Known food allergies:_____

Environmental allergies:_____

Patient Name:_____DOB:_____

Review Of Systems: Please Indicate any personal history below:

Constitutional Symptoms		**Genitourinary**		**Respiratory**	
Good General Health	□ No □ Yes	Blood in urine	□ No □ Yes	Asthma	□ No □ Yes
Fatigue	□ No □ Yes	Burning or painful urination	□ No □ Yes	Chronic/frequent coughs	□ No □ Yes
Fever	□ No □ Yes	Change in force or strain when urinating	□ No □ Yes	Shortness of breath	□ No □ Yes
Recent Weight Change	□ No □ Yes	Female-irregular periods	□ No □ Yes	Spitting up blood	□ No □ Yes
Eyes		Female-pain with periods	□ No □ Yes	Wheezing	□ No □ Yes
Blurred Vision	□ No □ Yes	Frequent urination	□ No □ Yes	**Gastrointestinal**	
Double Vision	□ No □ Yes	Incontinence	□ No □ Yes	Abdominal pain	□ No □ Yes
Eye Disease	□ No □ Yes	Kidney stones	□ No □ Yes	Blood in stool	□ No □ Yes
Eye Injury	□ No □ Yes	Male-testicle pain	□ No □ Yes	Change in bowel movements	□ No □ Yes
Wear glasses/contact lenses	□ No □ Yes			Constipation	□ No □ Yes
		Musculoskeletal		Frequent diarrhea	□ No □ Yes
Ears/Nose/Mouth/Throat		Back pain	□ No □ Yes	Loss of appetite	□ No □ Yes
Bad breath or bad taste	□ No □ Yes	Difficulty walking	□ No □ Yes	Nausea	□ No □ Yes
Bleeding gums	□ No □ Yes	Gout	□ No □ Yes	Painful bowel movements	□ No □ Yes
Chronic sinus problems	□ No □ Yes	Joint pain	□ No □ Yes	Rectal bleeding	□ No □ Yes
Drainage	□ No □ Yes	Joint stiffness	□ No □ Yes	Vomiting	□ No □ Yes
Earaches	□ No □ Yes	Joint swelling	□ No □ Yes		
Hearing loss	□ No □ Yes	Muscle cramps	□ No □ Yes	**Psychiatric**	
Mouth sores	□ No □ Yes	Muscle pain	□ No □ Yes	Depression	□ No □ Yes
Nose bleeds	□ No □ Yes	Varicose veins	□ No □ Yes	Insomnia	□ No □ Yes
Rhinitis	□ No □ Yes	Weakness of muscles/joints	□ No □ Yes	Memory loss/confusion	□ No □ Yes
Ringing in ears	□ No □ Yes			Nervousness	□ No □ Yes
Sore throat	□ No □ Yes				
Swollen glands in neck	□ No □ Yes			**Endocrine**	
Voice change	□ No □ Yes	**Integument (Skin)**		Change in hat/glove size	□ No □ Yes
		Change in hair/nails	□ No □ Yes	Cold intolerance	□ No □ Yes
Cardiovascular		Change in skin color	□ No □ Yes	Excessive thirst	□ No □ Yes
Chest pain or angina	□ No □ Yes	Itching	□ No □ Yes	Glandular/hormone problems	□ No □ Yes
Heart trouble	□ No □ Yes	Rash	□ No □ Yes	Heat intolerance	□ No □ Yes
Palpitation	□ No □ Yes			Skin becoming drier	□ No □ Yes
Swelling of ankles	□ No □ Yes	**Neurological**			
Swelling of feet	□ No □ Yes	Convulsions/seizures	□ No □ Yes	**Hematologic/Lymphatic**	
Swelling of hands	□ No □ Yes	Dizziness	□ No □ Yes	Anemia	□ No □ Yes
		Frequent headaches	□ No □ Yes	Blood clots	□ No □ Yes
		Head injury	□ No □ Yes	DVT	□ No □ Yes
		Lightheadedness	□ No □ Yes	Excessive bleeding	□ No □ Yes
		Numbness/tingling	□ No □ Yes	Past transfusion	□ No □ Yes
		Paralysis	□ No □ Yes	Phlebitis	□ No □ Yes
		Tremors	□ No □ Yes	Pulmonary Embolism	□ No □ Yes
				Slow to heal after cuts	□ No □ Yes

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X_____

Signature of patient (parent or guardian, if minor) **Date**