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Name:		**Preferred Name:**	
Date:		**Date of Birth:**	
Home Phone: ( )	**Work Phone:** ( )	**Email:**	
Primary Care Physician:		**Marital Status:** ☐ Divorced ☐ Separated ☐ Married ☐ Sig Other ☐ Single ☐ Widowed ☐ Other	
Maiden/Other Names:			
Emergency Contact 1:	Relation:	Hm: ( )	Wk: ( )
Emergency Contact 2:	Relation:	Hm: ( )	Wk: ( )

Health Concerns to Share With Provider

_____

_____

Smoking Status

☐ Never ☐ Current daily smoker ☐ Current intermittent smoker ☐ Former smoker (Quit _____/_____)

If yes, what do you smoke? ☐ Cigarettes ☐ Pipe ☐ Cigar Packs/day:_____ # Years:_____

Does anyone in the household smoke (passive smoker)? ☐ No ☐ Yes:_____

Smokeless (Chewing) Tobacco: ☐ Never ☐ Current ☐ Former (Quit _____/_____)

Alcohol Use

☐ Yes ☐ No **If yes, on average, how much do you drink per week?**

___ Cans of beer ___Drinks with 0.5 oz. alcohol ____Shots of liquor ___ Glasses of wine

General Medical History

☐ **Check here if there has been no change since you last completed this form.**

Have you been diagnosed with any other medical problems? (check all that apply)

☐ Allergies	☐ Diabetes Mellitus	☐ Liver problems
☐ Anemia	☐ Easy bleeding or blood clots	☐ Nerve or muscle disease
☐ Anxiety	☐ Emphysema	☐ Mental disorder
☐ Arthritis	☐ GERD	☐ Osteoporosis
☐ Asthma	☐ Gout	☐ Seizures
☐ Cancer	☐ Stroke	☐ Sleep apnea
☐ Clotting disorder	☐ Heart disease	☐ Stroke
☐ Circulatory disorders/vascular disease	☐ Heart murmur	☐ Substance abuse
☐ Congestive Heart Failure (CHF)	☐ High blood pressure	☐ Thyroid disease
☐ COPD	☐ HIV / AIDS	☐ Ulcers
☐ Rheumatologic condition	☐ Kidney disease	☐ Other:_____

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Please check all symptoms that you have had **IN THE LAST MONTH** that are **NOT RELATED TO** the reason you are being seen.

Personal Health Review

GENERAL

Weight change >10 lbs in past year.. ☐ No ☐ Yes
Loss of appetite ..... ☐ No ☐ Yes
Fevers/chills ..... ☐ No ☐ Yes
Night sweats ..... ☐ No ☐ Yes
Fatigue ..... ☐ No ☐ Yes
Trouble sleeping ..... ☐ No ☐ Yes

EYES/EARS/NOSE/THROAT

Visual problems ..... ☐ No ☐ Yes
Hearing problems ..... ☐ No ☐ Yes
Dizziness (vertigo)..... ☐ No ☐ Yes

HEART/ LUNGS

Chest pain or tightness ..... ☐ No ☐ Yes
Pain in legs with walking ..... ☐ No ☐ Yes
Swelling of legs/ankles ..... ☐ No ☐ Yes
Shortness of breath ..... ☐ No ☐ Yes

ABDOMEN

Abdominal pain/heartburn..... ☐ No ☐ Yes
Trouble swallowing ..... ☐ No ☐ Yes
Nausea/vomiting..... ☐ No ☐ Yes
Diarrhea ..... ☐ No ☐ Yes
Constipation ..... ☐ No ☐ Yes
Blood in stools ..... ☐ No ☐ Yes
Accidental bowel movements . ☐ No ☐ Yes

GENITAL/URINARY

Pain with urination..... ☐ No ☐ Yes
Urinary frequency/urgency ..... ☐ No ☐ Yes
Incontinence(leaking urine) ..... ☐ No ☐ Yes
Blood in urine ..... ☐ No ☐ Yes
Foul smelling urine ..... ☐ No ☐ Yes

SKIN

Skin rashes/itching ..... ☐ No ☐ Yes

MUSCLES / BONES

Neck or back pain/stiffness..... ☐ No ☐ Yes
Joint pain/stiffness ..... ☐ No ☐ Yes
Back pain ..... ☐ No ☐ Yes
Other chronic pain ..... ☐ No ☐ Yes

NERVOUS SYSTEM

Headaches..... ☐ No ☐ Yes
Weakness of arms/legs..... ☐ No ☐ Yes
Numbness (loss of feeling) of hands, arms or forearms..... ☐ No ☐ Yes
Numbness (loss of feeling) of thighs, legs or feet..... ☐ No ☐ Yes
Memory loss..... ☐ No ☐ Yes
Depressed/anxious mood..... ☐ No ☐ Yes

BLOOD & METABOLISM

Easy bruising/bleeding..... ☐ No ☐ Yes
Excessive thirst or urination ..... ☐ No ☐ Yes

If you are a female:

Is there any chance you could be pregnant now? ☐ No ☐ Yes

Are your symptoms worsened near your period? ☐ No ☐ Yes

Surgical History

☐ **Check here if there has been no change since you last completed this form.**

Surgical Procedure:	Date:

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Family History

☐ Check here if there has been no change since you last completed this form.

Are you adopted? ☐ Yes ☐ No

Check family members who have the following conditions:	No History	Mother	Father	Sister	Brother
Blood - Bleeding Disorder					
Blood - Clotting Disorder					
Cancer					
Endo - Diabetes					
Endo -Thyroid Disease					
Genetic Disorder					
GI (Stomach/Intestinal Problems)					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Neuro - Other Nerve or Muscular Disease					
Neuro - Stroke					
Osteoporosis					
Psych - Depression/Anxiety					
Psych - Other Disease					
Pulm - Asthma					
Rheum - Arthritis					
Rheum - Autoimmune Problems					
Substance Abuse					
Other:					

Allergies & Medications

Allergies (include reaction and date noted if known):

** Please continue on back of last page if needed.*

Medications (include dose if known):

** Please continue on back of last page if needed.*

Learning Assessment

Do you have any teaching considerations that we should be aware of?

- ☐ None
- ☐ Hearing impaired
- ☐ Vision impaired
- ☐ Fine motor impairment
- ☐ Memory impairment
- ☐ Difficulty reading
- ☐ Non-English speaking
- ☐ Aphasia (brain injury resulting in impaired ability to understand language)
- ☐ Attention deficit
- ☐ Cultural beliefs
- ☐ Spiritual beliefs
- ☐ Other _____

Are you right or left handed?_____

What is your preferred learning method?

- ☐ Written
- ☐ Audio-visual
- ☐ Demonstration
- ☐ Explanation
- ☐ Other _____

Strategies to assist your learning:

- ☐ Simple terminology
- ☐ Repeat information
- ☐ Read to me
- ☐ Use an interpreter
- ☐ Telephone language assist
- ☐ Voice amplifier
- ☐ Other _____

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Additional Allergies, Meds or Health History:

Patient Signature

Date/Time