

Patient Demographics						
Last Name		First Name		M	Nickname	
Address			City		State	Zip Code
Home Phone		Cell Phone		Work Phone	Birthdate (MM/DD/YY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Practice communication preference for Appts, Rx Notices, Test Results: <input type="checkbox"/> Phone <input type="checkbox"/> Text (SMS) <input type="checkbox"/> Both			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Social Security Number	
Employer Name			Occupation/Job Title			<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
Employer Address			City		State	Zip Code
Guarantor Information						
Last Name		First Name		M	Relationship to Patient	
Address			City		State	Zip Code
Home Phone		Cell Phone		Birthdate (MM/DD/YYYY)	Social Security Number	
Emergency Contact						
Relationship to Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Care Giver <input type="checkbox"/> Other _____			Last Name		First Name	M
Address			City		State	Zip Code
Home Phone		Cell Phone		Work Phone		
Primary Insurance Information						
Primary Insurance Company				Policy ID Number #		
Coverage Start Date (MM/DD/YY)	Subscriber/Insured Name			Patient Relationship to Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Care Giver <input type="checkbox"/> Sibling <input type="checkbox"/> Other _____		
Group Number #			Group Name			
Secondary Insurance Information						
Secondary Insurance Company				Policy ID Number #		
Coverage Start Date (MM/DD/YY)	Subscriber/Insured Name			Patient Relationship to Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Care Giver <input type="checkbox"/> Sibling <input type="checkbox"/> Other _____		
Group Number #			Group Name			



Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

**Chief Complaint**

What is the main reason for your visit ? (Describe your problem in detail) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**History of Present Illness**

Location of the problem: \_\_\_\_\_ How long does the problem last: \_\_\_\_\_

When did you first notice the problem? \_\_\_\_\_

Is the problem constant or variable?  Dull then sharp  Very sharp then stops  Constant

Is anything else occurring at the same time?  Yes  No If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

On a scale of 0 – 10, with 0 being the least painful and 10 being the most painful. Circle the number of your pain below:

Less pain 0 1 2 3 4 5 6 7 8 9 10 More pain

**Past Medical History**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Gall Bladder Disease       | <input type="checkbox"/> Liver Problems      | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Reflux/Heart Burn    |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke/Mini-stroke         | <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> Kidney Problems      |
| <input type="checkbox"/> Seizure Disorder  | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Neck/Back Problem | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Cancer: Organ _____ |   |

**Past Procedure History**

- |  | <u>Date (Year)</u> |  | <u>Date (Year)</u> |
|--|--------------------|--|--------------------|
| <input type="checkbox"/> Heart Bypass/Valve Replacement        | _____              | <input type="checkbox"/> Stomach Surgery   | _____              |
| <input type="checkbox"/> Hernia Repair                         | _____              | <input type="checkbox"/> Appendix Removal  | _____              |
| <input type="checkbox"/> Gallbladder Removed                   | _____              | <input type="checkbox"/> Back/Neck Surgery | _____              |
| <input type="checkbox"/> Joint Replacement                     | _____              | <input type="checkbox"/> Tonsils Removal   | _____              |
| <input type="checkbox"/> Bladder/Kidney Surgery                | _____              | <input type="checkbox"/> Organ Transplant  | _____              |
| <input type="checkbox"/> Mammogram                             | _____              | <input type="checkbox"/> Pneumonia Vaccine | _____              |
| <input type="checkbox"/> Pap Smear (cervical cancer screening) | _____              | <input type="checkbox"/> Flu Vaccine       | _____              |
| <input type="checkbox"/> Colonoscopy                           | _____              | <input type="checkbox"/> COVID Vaccine     | _____/_____        |

	Alive, Deceased, Unknown	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown	Other
Father										
Mother										
Son(s)										
Daughter(s)										
Brother(s)										
Sister(s)										
Paternal Grandfather										
Paternal Grandmother										
Maternal Grandfather										
Maternal Grandmother										

How many of the following do you have?

Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Sons \_\_\_\_\_ Daughters \_\_\_\_\_

### Social History

#### Tobacco Use

- CURRENT SMOKER
- How many? \_\_\_\_\_ Date started? \_\_\_\_\_ How often?  Every day  Some days
- 5 or less  6-10  11-20  21-30  31+
- How soon after you wake?  Within 5min  6-30min  31-60min  after 60min
- Interested in quitting?  Ready to quit  Thinking  Not ready
- FORMER SMOKER
- Date last smoked? \_\_\_\_\_
- How long since last smoked?  1-3 months  3-6 months  6-12 months  1-5 years  5+ years
- What type?  Cigarettes  Cigars  Smokeless  Pipe  Other
- NEVER SMOKED

#### Alcohol Use

- Did you have a drink in the past year?  Yes  No
- How often?  Mthly  2-4 times a mth  2-3 times a wk  4 or more a wk
- How many drinks on a typical day?  1-2  3-4  5-6  7-9  10+
- How often you have 6 or more on occasion:  Never  Monthly  Weekly  Daily

#### Illicit Drug Use

- Have you used drugs other than those for medical reasons in the past year?  Yes  No
- What type?  Amphetamines  Cocaine  Ecstasy  LSD  Crack  Meth
- Prescription Opiates  Heroin  Marijuana  Suboxone  PCP
- Route?  Injected  Intranasal  Smoked
- Frequency?  Daily  Weekly  Monthly
- Are you in treatment?  Yes  No

#### Living Situation

- Homeless/History of Homelessness  Alone  Spouse or Significant Other  Family or Friends



<p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abdominal Pain</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Burping</li> <li><input type="checkbox"/> Blood in stool</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Cardiovascular</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest Pain</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Swelling of extremities</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Constitutional Symptoms</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Chills</li> <li><input type="checkbox"/> Sweating</li> <li><input type="checkbox"/> Weight loss</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Other _____</li> </ul>
<p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Skin rash</li> <li><input type="checkbox"/> Boils</li> <li><input type="checkbox"/> Persistent itch</li> <li><input type="checkbox"/> Change in fingernails</li> <li><input type="checkbox"/> Hair loss</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Eyes</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurred Vision</li> <li><input type="checkbox"/> Double Vision</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Musculoskeletal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Joint pain</li> <li><input type="checkbox"/> Back pain</li> <li><input type="checkbox"/> Neck pain</li> <li><input type="checkbox"/> Other _____</li> </ul>
<p><b>Ear / Nose / Throat</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ear pain</li> <li><input type="checkbox"/> Hard of hearing</li> <li><input type="checkbox"/> Sore throat</li> <li><input type="checkbox"/> Runny nose</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Hematologic / Lymphatic</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Swollen glands</li> <li><input type="checkbox"/> Easy bruising</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Neurological</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Dizzy spells</li> <li><input type="checkbox"/> Memory Problems</li> <li><input type="checkbox"/> Frequent Headaches</li> <li><input type="checkbox"/> Other _____</li> </ul>
<p><b>Respiratory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Frequent cough</li> <li><input type="checkbox"/> Sputum</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Endocrine</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Allergic / Immunologic</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Seasonal allergies</li> <li><input type="checkbox"/> Sneezing</li> <li><input type="checkbox"/> Watery/Itchy Eyes</li> <li><input type="checkbox"/> Other _____</li> </ul>
<p><b>Female Genitourinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Urgent urination</li> <li><input type="checkbox"/> Pain on urination</li> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Urine leakage</li> <li><input type="checkbox"/> Lower abdominal pain</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Painful menstruation</li> <li><input type="checkbox"/> Other _____</li> </ul>		<p><b>Male Genitourinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain in the testicles</li> <li><input type="checkbox"/> Penile discharge</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Night time urination</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Dribbling of urine</li> <li><input type="checkbox"/> Difficulty starting urine</li> <li><input type="checkbox"/> Other _____</li> </ul>