Please answer the following questions and bring to your appointment along with your medications. It will help your physician to collect information about you and your family. This document will be filed as part of your permanent record. **PLEASE USE A BLACK OR BLUE PENS, NOT PENCIL TO COMPLETE FORM**

Phone ______________________ **Address** ____

Age ______ **Sex M F** ❑ **Married** ❑ **Single** ❑ **Widowed** ❑ **Divorced** ❑ **Separated**

Religion ______________________ **Education** ______________________ **Occupation** ______________________ **How long?**___________

Wife / Husband / Partner: Name: ______________________ **Age** ______ **Health** ________________ **Years married** _________

Children: # ______ **Name:**__________________ **Age** ______ **Name:**____________________ **Age** ______ **Name:**____________________ **Age** _____

List All Past Illness / Disease	Date	List All Operations	Date
❑ Updated in MyChart		❑ Updated in MyChart	

Menstrual History: Age at first period _______ Date of last period ______________ Length of cycle _________ Number of days of flow ______

Hormone Replacement Therapy? Y N Hx of abnormal pap? Y N Number of pregnancies _______ Number of miscarriages ______

Sexual History: Is your sexual partner ❑ Male ❑ Female ❑ Both Hx STD: Y N ❑ Gonorrhea ❑ HPV ❑ Chlamydia ❑ Herpes

Contraceptive Use? Y N Type: ❑ Tubal ❑ Vasectomy ❑ Pill ❑ Injection ❑ Barrier ❑Rhythm ❑Other _____________

Please CIRCLE illnesses or conditions you may have had

Diabetes	Heart Disease	Kidney Disease	Liver Disease	Asthma	Blood Transfusion	Emphysema	Intestinal Problems
Arthritis	Stomach Ulcers	Urinary Trouble	Bleeding Tendency	Bronchitis	Vein Trouble	HIV	Nervous Disorder
Cancer	Glaucoma	Osteoporosis	Rheumatic Fever	Seizures	Chemical Dependency		Depression

List all Medications [Please include any 'Over the counter' or non-prescription medicines. Bring all medicines to appointment.]

Medication	Dose	Medication	Dose
❑ Updated in MyChart			

List ALLERGY to medicines or other substances ____ Latex Allergy? Y N

FAMILY HISTORY [List chronic medical problems as well as cause of death]

	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	OTHER MEDICAL PROBLEMS
❑ Updated in MyChart				
Father				
Mother				
Brothers				
Sisters				
Children				

See Other Side →

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Do you use tobacco now? ________ In the past? __________ How many years did you use tobacco? _________

Type and daily amount ____________________When did you quit smoking? ______________Do you want help to quit smoking? Y N

Do you use alcoholic beverages? _______ Type _____________________ Weekly amount ____________ For how many years? ________

Have you used any other recreational drugs? ________ Type? _________________________________ For how many years? __________

Do you exercise? _________ How often? ___________________________ Do you wear your seat belt while in a car? ____________

Do you feel safe in your home and in your relationships? Y N

Do you have an Advanced Directive? Y N If No, are you interested in discussing with your provider? Y N

What is the main reason for visit today?____

Please CIRCLE any active problems

Constitutional	Fatigue Fever Chills Night Sweats
Eyes	Vision Problems Eye Pain Red Eyes Discharge From Eyes Dry Eyes Eyes Itch
Ears Nose Throat	Ringing Loss of Hearing Earache Difficulty Swallowing Sore Throat Hoarseness Sores in mouth Allergy (runny nose or searsonal allergy) Nosebleeds Stuffiness (nasal congestion)
Cardiovascular	Chest Pain Palpitations Ankle Swelling Legs Ache with Walking Varicose Veins
Respiratory	Cough Wheezing Snoring Shortness of Breath Sputum Hemoptysis
Breast	Discharge Lumps Pain
GastroIntestinal	Abdominal Pain Constipation Diarrhea Heartburn Rectal Bleeding (Hematochezia) Black,tarry stools (Melena) Nausea/Vomiting Hemorrhoids
Genito-urinary	Pain on Urination (Dysuria) Blood in Urine (Hematuria) Lack of Control (Incontinence) Night Urination (Nocturia) Sexual Problem Do you leak when you cough or sneeze? Y N Do you leak urine at any other time? Y N Would you like to discuss this with your provider? Y N
Gynecologic (female only)	Painful Intercourse (dyspareunia) Abnormal Vaginal Bleeding Pelvic Pain Painful Periods (Dysmenorrhea) Vaginal Discharge Menopausal symptoms
Musculoskeletal	Joint Pain Joint Swelling Muscle Pain Muscle Weakness Back Pain Are you interested in being screened for osteoporosis? Y N
Skin	Rash Change in a mole Skin Lesions Itching
Neuro	Dizziness Headache Weakness Imbalance Tingling/numbness Confusion Fainting (Syncope)
Psychiatric	Sleep Disturbances Depression Anxiety Change in mood Chemical dependency Family problems
Endo	Weight Gain/Loss Heat Intolerance Cold Intolerance Hair Loss (alopecia) Excessive thirst (Polydipsia)
Heme	Bleeding gums Easy Bleeding Easy Bruising Swollen Glands
Other	

Physician Notes:

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Initial______________________Date_____________________

1/3/13, 11/12/14, (format) 9/2/15 (HC), 2/17/17 LS, kmb

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