**Today's Date: _____**

This form is very important to you and your doctor. We want to double-check all that we know about you as we update our records on a yearly basis. Please spend a great deal of energy filling it out correctly and completely.

Name (Last, First, Initial): _____

Home Address: _____

Home Number: _____ Cell Phone: _____ Work Number: _____

Email Address: _____ Occupation _____

Status: [ ] 1 – Married [ ] 2 – Single [ ] 4 – Other [ ] 6 – Separated [ ] 7 – Divorced [ ] 5 – Widowed

Birthdate: _____ Age _____ Sex: _____ Social Security # _____

Communication: **(Please circle one)** Deaf Hard of Hearing Blind Other _____

Advanced Care Planning *(ie: POA, End of Life, Advanced Directives):* _____

**Medications:** (Name, Dose, and when taken) _____

_____

_____

**Allergies to medicines:** (Yes/No/What Medications?) _____

**Surgeries:** (What did you have and when) _____

_____

_____

**Medical History:** (List all hospitalizations, or any chronic medical condition for which you've seen a doctor) _____

_____

_____

**Social History:**

Have you/Do you use illicit/recreational drugs? If so which ones? _____

If you drink alcoholic beverages, how much & how often? _____

If you chew, smoke or have ever used tobacco, what age did you start? How much do you use a day? _____

Any other social history? *(ie: vaping, literacy, housing, etc.)* _____

***Name:*** _____ ***Date:*** _____

| **Your Family History: (Any diseases or illnesses in children, parents, or grandparents.)** | | | |
|---|---|---|---|
| Name of family member | Age | Health Problems | Cause & Age at Death |
| Father: | | | |
| Mother: | | | |
| Siblings: | | | |
| | | | |
| | | | |
| Paternal Grandfather: | | | |
| Paternal Grandmother: | | | |
| Maternal Grandfather: | | | |
| Maternal Grandmother: | | | |
| Spouse: | | | |
| Children: | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***Name:*** _____ ***Date:*** _____

***Please check any boxes that are <u>current</u> problems you would like to discuss with the doctor. This sheet is <u>confidential</u> and is private information between you and your doctor. New patients should fill out completely. If this is a <u>past</u> condition, indicate date next to problem.***

## Habits
- ☐ Smoke cigarettes or chewing tobacco
- ☐ More than 2 alcoholic drinks daily
- ☐ Used recreational drugs
- ☐ Don't exercise regularly

## Nutrition
- ☐ Like salt and salty foods
- ☐ Weight gain/ loss of >15 lbs in past 1 year
- ☐ Regularly eat fast food, cakes, cookies
- ☐ Would like help with diet

## Blood & Lymphatic
- ☐ Frequent infections
- ☐ Have you had a blood transfusion
- ☐ Do you have anemia
- ☐ Lumps in neck, armpits, or groin

## Skin, Nails, & Hair
- ☐ Hair loss
- ☐ Nail Change
- ☐ Excessive itching
- ☐ Dry Skin
- ☐ Rash
- ☐ Abnormal sore/mole/growth
- ☐ Changing moles (color or shape)
- ☐ Unwanted Birth Marks
- ☐ Unusual or Excess Hair Growth
- ☐ Acne

## Breasts
- ☐ Nipple discharge/bleeding
- ☐ Skin dimpling
- ☐ Pain
- ☐ Change in size
- ☐ Lumps
- ☐ Family history of breast Cancer

## Sexuality
- ☐ Have Birth control needs
- ☐ Would like to discuss sexual concerns
- ☐ Worried about past sexuality
- ☐ Want HIV test

## Head
- ☐ Have you had a severe head trauma
- ☐ Severe headaches
- ☐ Sinusitis
- ☐ Allergies
- ☐ Visual loss
- ☐ Double vision
- ☐ Hearing loss
- ☐ Voice hoarseness
- ☐ Ringing in ears
- ☐ Frequent nose bleeds
- ☐ Lip/Gum/Mouth sores

## Neck
- ☐ Stiffness
- ☐ Masses

## Lungs
- ☐ Get excessively sleepy while driving
- ☐ Early morning headaches
- ☐ Blood clots
- ☐ Asthma
- ☐ Snore loudly at night
- ☐ Emphysema/COPD
- ☐ Tuberculosis or exposure to TB
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Stop breathing at night

## Cardiovascular
- ☐ Wake up at night short of breath
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Chest pressure, pain or tightness
- ☐ Irregular heartbeat
- ☐ Shortness of breath on exertion
- ☐ Can't sleep flat
- ☐ Urinate more than once after bedtime
- ☐ Ankles swell
- ☐ High blood pressure
- ☐ Do your feet get cold easily?

## Neurological/Musculoskeletal
- ☐ Loss of consciousness
- ☐ Memory loss/forgetfulness
- ☐ Confusion
- ☐ Stroke
- ☐ Numbness/tingling _____(location)
- ☐ Dizziness
- ☐ Back Pain _____
- ☐ Other Pain _____

## Prevention Year of most recent:
- ☐ Pap Smear _____
- ☐ Breast Exam _____
- ☐ Mammogram _____
- ☐ Digital Rectal Exam _____
- ☐ Test for blood in stool _____
- ☐ Sigmoidoscopy _____
- ☐ Colonoscopy _____
- ☐ Bone density test _____
- ☐ TB Skin Test _____
- ☐ Tetanus Immunization _____
- ☐ Flu Shot _____
- ☐ Hepatitis C test _____
- ☐ Pneumonia Shot _____
- ☐ PSA Prostate blood _____
- ☐ Cholesterol Test _____
- ☐ Do you take an Aspirin daily?
- ☐ Vision Exam _____

## Gastrointestinal
- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Acid Reflux
- ☐ Heartburn or indigestion
- ☐ Food intolerance
- ☐ Nausea or vomiting
- ☐ Vomiting of blood
- ☐ Ulcers
- ☐ Abdominal pain
- ☐ Hepatitis/liver disease/jaundice
- ☐ Gall bladder disease
- ☐ Pancreatitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Black stools/Black tarry streaks in stools
- ☐ Family history of colon polyps
- ☐ Family history of colon cancer
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Stool incontinence

## Genitourinary
- ☐ Kidney stones
- ☐ Burning with urination
- ☐ Urinary frequency/urgency
- ☐ Blood in urine
- ☐ Difficulty starting urine
- ☐ Infertility
- ☐ Urine incontinence/Leaking

MALE
- ☐ Impotence/ejaculatory problems
- ☐ Scrotal/testicle mass or enlargement
- ☐ Hernia
- ☐ Prostate problems
- ☐ Family history of prostate cancer
- ☐ Weak urine stream
- ☐ Penile lesion/discharge/STDs

FEMALE
- ☐ Bleeding after menopause
- ☐ Abnormal periods
- ☐ Sores/lesions/STDs
- ☐ Vaginal discharge/itching
- ☐ Pain with intercourse
- ☐ Abnormal pap smears
- ☐ Hot flashes
- ☐ Bleeding after intercourse

## Psychiatric
- ☐ Mood problems
- ☐ Anxiety
- ☐ Concentration problems
- ☐ Suicidal thoughts
- ☐ Need counseling

☐ *Are there any other medical problems not listed above you would like to discuss:* _____

_____