Patient's Name: _____ **Today's Date:**_____

DOB_____

Medications (Name, Dosage and Frequency)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

(Please request additional medication page from our staff if necessary)

Pharmacy Name: _____ **Telephone number:**_____

Allergies: (Medications or food)_____

Immunizations: (Date administered)

Seasonal Influenza (Flu Shot):_____
Pneumovax(Within the last 5 years)_____
Other:_____

Primary Care Physician and othe

1._____ 3._____

2._____ 4._____

Family History of Illnesses

Kidney Disease	Father	Yes	No	Gout	Father	Yes	No
	Mother	Yes	No		Mother	Yes	No
	Sibling	Yes	No		Sibling	Yes	No
	Child	Yes	No		Child	Yes	No
Diabetes	Father	Yes	No	Polycystic	Father	Yes	No
	Mother	Yes	No	Kidney	Mother	Yes	No
	Sibling	Yes	No		Sibling	Yes	No
	Child	Yes	No		Child	Yes	No
High Blood	Father	Yes	No	Dementia	Father	Yes	No
Pressure	Mother	Yes	No		Mother	Yes	No
	Sibling	Yes	No		Sibling	Yes	No
	Child	Yes	No		Child	Yes	No
Ischemic Heart	Father	Yes	No		Living	Yes	No
Disease	Mother	Yes	No	Father	At what age		
	Sibling	Yes	No		Cause of Death		
	Child	Yes	No		Unknown		
Cancer	Father	Yes	No				
	Mother	Yes	No	Mother	Living	Yes	No
	Sibling	Yes	No		At What Age		
	Child	Yes	No		Cause of Death		
					Unknown		
	Father	Yes	No				
Stroke	Mother	Yes	No				
	Sibling	Yes	No				
	Child	Yes	No				

Patient's Social History

	Current User	Yes	No		Current User	Yes	No
Tobacco Use	How Many Packs a day			Alcohol Use	Occasional	Yes	No
	Former User	Yes	No		1-2 drinks per day	Yes	No
	Tobacco	Yes	No		3 or more drinks per day	Yes	No
	Cigar	Yes	No		Former User	Yes	No
	Other	Yes	No		1-2 drinks per day	Yes	No
	Date Stopped				3 or more drinks per day	Yes	No
	Never Used	Yes	No		Never Used	Yes	No

E-MAIL:

Review of Systems							
Constitutional	Fever	Yes	No	Genitourinary	Urinary urgency	Yes	No
	Weight gain	Yes	No		Urinary Burning or Pain	Yes	No
	Weight loss	Yes	No		Blood in Urine	Yes	No
	Fatigue	Yes	No		Urinary Frequency	Yes	No
	Chills	Yes	No		Urinary Hesitancy	Yes	No
	Weakness	Yes	No		Foamy Urine	Yes	No
					Incontinence	Yes	No
HEENT	Vision impaired	Yes	No		Urinating at night	Yes	No
	Cataract	Yes	No				
	Eye pain	Yes	No	Musculoskeletal	Back pain	Yes	No
	Redness	Yes	No		Neck Pain	Yes	No
	Color Blindness	Yes	No		Joint Pain	Yes	No
	Hearing Loss	Yes	No		Muscle Pain	Yes	No
	Double Vision	Yes	No		Arm Weakness	Yes	No
	Ear Pain	Yes	No		Left	Yes	No
	Sinus Problems	Yes	No		Right	Yes	No
	Sore throat	Yes	No		Both	Yes	No
	Nose bleeds	Yes	No		Leg Weakness	Yes	No
	Headache	Yes	No		Left	Yes	No
	Hoarseness	Yes	No		Right	Yes	No
	Ringing of ears	Yes	No		Both	Yes	No
	Dizziness	Yes	No				
				Skin	Rashes	Yes	No
Respiratory	Shortness of breath	Yes	No		Itching	Yes	No
	At Rest	Yes	No		Scaling	Yes	No
	With Activity	Yes	No		Dryness	Yes	No
	Pain with Breathing	Yes	No		Color Change	Yes	No
	Cough	Yes	No				
	Wheezing	Yes	No	Neurological	Numbness	Yes	No
	Blood in Sputum	Yes	No		Tremors	Yes	No
	Nights Sweats	Yes	No		Seizures	Yes	No
					Tingling	Yes	No
Cardiovascular	Chest Pain	Yes	No		Fainting	Yes	No
	Palpitations	Yes	No				
	Pain in Legs while walking	Yes	No	Psychiatric	Depression	Yes	No
	SOB while Lying flat	Yes	No		Insomnia	Yes	No
	Edema	Yes	No		Anxiety	Yes	No
	Breathing Diffulty while lying	Yes	No				
				Endocrine	Heat intolerance	Yes	No
Gastrointestinal	Abdominal pain	Yes	No		Cold intolerance	Yes	No
	Nausea	Yes	No		Excessive Thirst	Yes	No
	Diarrhea	Yes	No		Excessive Urination	Yes	No
	Heart Burn	Yes	No				
	Vomiting	Yes	No	Hematology /	Bleeding gums	Yes	No
	Constipation	Yes	No	Oncology	Easy Bruising	Yes	No
	Anorexia	Yes	No				
	Trouble Swallowing	Yes	No	Immuno/	Seasonal Allergies	Yes	No
	Indigestions	Yes	No	Allergy	Hives	Yes	No