Name:_____ **DOB:**_____

PERSONAL MEDICAL AND FAMILY HISTORY

Please check applicable boxes.

TOBACCO USE: ☐ **None** **Quit Date**_____
☐ **Cigarettes** **Packs/Day**_____ **Number of years smoked**_____ ☐ **Pipe/Cigar**
☐ **Smokeless Tobacco** ☐ **Electronic or E-cigarette** ☐ **Secondhand smoke exposure**

ALCOHOL ABUSE: (please circle) **None** **Daily** **Occasional** **Trying to Cut Down** **In Recovery**
Amount per week:_____

DRUG USE: ☐**None** ☐**Past Use** ☐ **Current**
☐ **Marijuana** ☐ **Amphetamines** ☐ **Cocaine** ☐ **Designer/Club**
☐ **Route:** ☐ **Smoke** ☐ **Inject** ☐ **Ingest** ☐ **Topical**

How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?
☐ **None** ☐ **One or More**

ADVANCE DIRECTIVE
Do you have a living Will/DNR? ☐ **YES** ☐ **NO**
Do you have a Durable Power of Attorney? ☐ **YES** ☐ **NO**
If yes:_____
Please Print Name **Phone Number**

IMMUNIZATIONS:
Please provide any known dates or full immunization record(s).
Tetanus or Tetanus/Pertussis:_____ **Influenza:**_____ **Shingles:**_____
Meningitis_____
Hepatitis A:_____ _____ **Hepatitis B:**_____ _____
_____
HPV:_____ _____ _____ **Pneumovax:**_____ **Prevnar 13 :**_____
Other:_____

ALLERGIES: **Known Drug Allergies:** ☐ **YES** ☐ **No**
(Please add additional sheet if necessary)
Medication:_____ **Reaction:**_____
Medication:_____ **Reaction:**_____
Medication:_____ **Reaction:**_____
Medication:_____ **Reaction:**_____
Medication:_____ **Reaction:**_____
Medication:_____ **Reaction:**_____
Medication:_____ **Reaction:**_____
Medication:_____ **Reaction:**_____
Other Allergies (latex, adhesive, food, environmental)
Substance:_____ **Reaction:**_____
Substance:_____ **Reaction:**_____
Substance:_____ **Reaction:**_____
Substance:_____ **Reaction:**_____

SIGNATURE:_____ **DATE:**_____
(Patient or Authorized Representative)

Name:_____ **DOB:**_____

FAMILY HISTORY

What illness/conditions/diagnoses are in your family?

If known, document the age of onset in the box for the appropriate disease and family member.

	Father	Mother	Sibling(s)	Paternal Grandparent(s)	Maternal Grandparent(s)
Alcoholism/ Substance abuse					
Asthma					
Blood clots					
Breast cancer					
Colon cancer					
Prostate cancer					
Other cancer(s)					
Dementia					
Diabetes					
Heart disease					
High blood pressure					
High cholesterol					
Kidney disease					
Liver disease					
Lung disease					
Mental health/psychiatric					
Stroke					
Thyroid condition(s)					
Other					

SIGNATURE:_____ **DATE:**_____

(Patient or Authorized Representative)

Patient Name:_____ **DOB:**_____

Please circle all that you've experienced over the LAST TWO WEEKS

General/ Constitutional	Appetite change Excessive sweating Fatigue	Fever Chills Insomnia	Night sweats Weight gain Weight loss	None
Eyes	Blurred Vision Wear corrective lenses Double vision	Dry eye Eye irritation Eye Pain	Vision loss Spots in vision	None
Ear, Nose & Throat	Ear Pain Hearing loss Tinnitus/ringing Vertigo (dizziness, balance problems) Facial pain	Bleeding gums Postnasal drainage Nose bleeds Nasal congestion Nasal drainage	Sore throat Mouth sores Hoarseness Dental pain	None
Cardiovascular	Exertional dyspnea (trouble breathing) Nocturnal dyspnea (trouble breathing)	Palpitations (irregular heartbeat) Decreased exercise tolerance	Chest pain Exertional dyspnea	None
Respiratory	Cough Sputum production Coughing up blood	Wheeze Pain with inspiration (deep breath Shortness of breath	Snoring	None
Gastrointestinal	Abdominal pain Bloating Food intolerance Nausea	Trouble swallowing Heartburn Change in bowel habits Constipation	Diarrhea Vomiting Bloody stools Black stools	None
Genitourinary	Change in urine stream Dysuria (painful urination) Hematuria (blood in urine) Incontinence	Nocturia (overnight urination) Urinary frequency Urinary retention Menstrual changes/concerns	Urinary urgency Sexual dysfunction Vaginal discharge	None
Musculoskeletal	Back pain Joint instability Joint pain Joint swelling	Limited range of motion Leg pain at night Leg pain with exertion Neck pain	Stiffness Muscle cramps Muscle weakness Muscle aches	None
Integumentary/ Skin	Hair changes Lesions/changes in moles Breast masses	Pigment changes Rash Pruritus/persistent itch	Psoriasis	None
Neurologic	Abnormal gait/walking Focal weakness Headache(s) Confusion Memory problems	Seizures Decreased sensation Balance problems Restless legs Other neurologic concern	Speech problems Twitches/spasms Tremor Tingling Numbness	None
Psychiatric	Anxiety Decreased concentration Irritability Suicidal thoughts	Thought of hurting others Panic attacks Insomnia Mood swings	Sadness/tearfulness Depression Excessive sleep Hallucinations	None

Endocrine	**Cold intolerance** **Heat intolerance**	**Excessive thirst** **Excessive hunger**	**Excessive urination**	**None**
Hematologic/ Lymph	**Bruising tendency** **Bleeding tendency**	**Swollen glands** **Recurrent infections**		**None**
Allergy/ Immunologic	**Eczema** **Immunocompromised**	**Seasonal allergies** **Hives/Urticaria**		**None**
Any other symptoms:				

SIGNATURE:_____ **DATE:**_____

(Patient or Authorized Representative)

Patient Name:_____ **DOB:**_____

Your Care Team (other health care providers)

Provider: _____ **Specialty:**_____ **Phone:**_____
Provider: _____ **Specialty:**_____ **Phone:**_____
Provider: _____ **Specialty:**_____ **Phone:**_____

Procedures (list year):

Colonoscopy:_____ **Sigmoidoscopy:**_____ **Stress Test:**_____
EKG:_____
Mammogram:_____ **DEXA Scan:**_____

Please list any hospitalizations excluding surgeries/procedures

Hospitalized for	Year

Surgical History **Please list surgeries/procedures and add notes as needed other than listed above**

YEAR	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

MEDICATIONS: ☐ **None**

Please list any medications you are taking (including aspirin, vitamins and supplements), dosage, and how often you take.

Current Medications

Name of Medication	Dose	How often do you take	Reason for taking medication

PREFERRED PHARMACY

Local:_____ **Mail Order:**_____

SIGNATURE:_____ **DATE:**_____

(Patient or Authorized Representative)