

Name _____ Chart No. _____

GENERAL MEDICAL INFORMATION

Describe the current medical problem/reason for today's visit _____

Present medication _____

Allergies (Drugs/Food/Other) _____

Other physicians currently treating you _____

Previous or other Medical problems _____

List ANY previous surgeries or hospitalizations (include number of miscarriage and live births):

FEMALE ONLY: Are you pregnant, planning a pregnancy or nursing a child? YES NO

MEDICAL HISTORY (Check all that Apply)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Hypertension / High Blood Pressure | <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Ulcer: Stomach / Skin | <input type="checkbox"/> Osteoporosis / Osteopenia |
| <input type="checkbox"/> Hyperlipidemia / Cholesterol | <input type="checkbox"/> Anxiety / Fatigue | <input type="checkbox"/> GI Disorder / GERD / Reflux | <input type="checkbox"/> Gout / Arthritis |
| <input type="checkbox"/> Heart palpitations / Murmur | <input type="checkbox"/> Healing Problems | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Endocrine Disease/Thyroids |
| <input type="checkbox"/> Chest pain / Angina | <input type="checkbox"/> Scarring / Keloids / Malignancy | <input type="checkbox"/> Menstrual Dysfunction | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> MI / Stroke / TIA | <input type="checkbox"/> Allergies / Hay Fever | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Scarlet / Rheumatic Fever |
| <input type="checkbox"/> Diabetes Type I / Type II | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Broken/Fracture Bones |
| <input type="checkbox"/> Low Blood Flow / Claudication | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Muscle / Joint Problems | <input type="checkbox"/> Liver Disease / Hepatitis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Headache / Migraines | <input type="checkbox"/> Congenital Heart Problem | <input type="checkbox"/> Blood Disorder/Sickle Cell |

HABITS

- | | | |
|--|--|--|
| <input type="checkbox"/> Smoke: Packs Daily _____
How long? _____ | <input type="checkbox"/> Coffee: Cups Daily _____
<input type="checkbox"/> Caffeinated Drinks Daily _____ | <input type="checkbox"/> Sleep: Difficulty Sleeping _____
Sleep Apnea _____
Treatment: _____ |
| <input type="checkbox"/> Exercise Routine _____ | | <input type="checkbox"/> Alcohol: _____ |

- Hepatitis A/B/C risk factor:
- | | | |
|--|--|---|
| <input type="checkbox"/> Contact with blood/bodily fluids | <input type="checkbox"/> Blood transfusion prior to 1992 | <input type="checkbox"/> IV drug use (1+ times) |
| <input type="checkbox"/> Travel – Out of the U.S (1 Or More years) | <input type="checkbox"/> Tattoos | <input type="checkbox"/> Body Piercing |

IMMUNIZATIONS (Most Recent Date)

Tetanus _____ Pneumonia _____ Influenza/ H1N1 _____ HEP B/ HEP C _____

Family History (Circle all that Apply)

Hypertension:	Father	Mother	Grandparents	Siblings	Children
Stroke:	Father	Mother	Grandparents	Siblings	Children
Cancer:	Father	Mother	Grandparents	Siblings	Children
Diabetes:	Father	Mother	Grandparents	Siblings	Children
Kidney/Thyroid:	Father	Mother	Grandparents	Siblings	Children
Osteoporosis:	Father	Mother	Grandparents	Siblings	Children

Parents Age: Father _____ Mother _____

OFFICE USE ONLY

Date _____ Next Update Due _____