Thank you for choosing our clinic for your healthcare needs! We appreciate your assistance with completing this form as it will help us better care for you. This is confidential information, and will be kept in your electronic medical record.

Were you referred by another physician? If so, who?

___________________________________________________________________________________________________________________________

Please describe the reason for your visit today. Please include the date of onset and any symptoms associated with the problem.

___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________

**Medications**

Medication name | Dose and frequency | Need Refill (Y/N)?
---|---|---

| | |
|---|---|---|
| | |
| | | 
| | |
| | | 
| | | 

**Allergies** (foods and drugs)

Please indicate type of reaction next to each.

___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________

**Advanced Directives**

Do you have Advanced Directives? (such as living will, power of attorney, etc.)  Yes___ No___
If yes, please specify.

___________________________________________________________________________________________________________________________
**Past Medical History/Problems** (check all that apply)

- ___ Abnormal Pap Smear
- ___ Depression
- ___ Hepatitis B
- ___ Rheumatoid Arthritis
- ___ Anemia
- ___ Diabetes, Gestational
- ___ Hepatitis C
- ___ Seizure Disorder
- ___ Anxiety
- ___ Diabetes Type 1
- ___ Hypertension
- ___ Skin Cancer
- ___ Asthma
- ___ Diabetes Type 2
- ___ Hyperthyroidism
- ___ Substance Abuse
- ___ Atrial Fibrillation
- ___ Diverticulosis
- ___ Hypothyroidism
- ___ Thyroid Disorder
- ___ Bipolar Disorder
- ___ DVT
- ___ Kidney Stone
- ___ Tuberculosis
- ___ Blood Transfusion
- ___ Dyslipidemia
- ___ Liver Disease
- ___ UTI – recurrent
- ___ Breast Ca.
- ___ Fibrocystic Breast Disease
- ___ Heart Attack
- ___ Varicose Veins/Phlebitis
- ___ Cervical Ca.
- ___ GERD
- ___ Osteoarthritis
- ___ NO MEDICAL PROBLEMS
- ___ Chronic Back Pain
- ___ Gout
- ___ Osteoporosis
- ___ Colon Cancer
- ___ Gl Bleed (upper/lower)
- ___ Peptic Ulcer Disease
- ___ COPD
- ___ Coronary Heart Disease
- ___ Peripheral Vascular Disease
- ___ Crohns Disease
- ___ Congestive Heart Failure
- ___ Prostate Cancer
- ___ CVA /Stroke
- ___ Valvular Heart Disease
- ___ Renal Failure
- ___ Dementia
- ___ Hepatitis A
- ___ Renal Insufficiency

Please explain any items you checked and list any medical problems not included:

_____________________________________________________________________________________________________________________________ ____________________
_______________________________________________________________________________________________________________ __________________________________
_____________________________________________________________________________________________________________________________ ____________________
_________________________________________________________________________________________________________________________________________________

**Past Surgical History** (check all that apply)

- ___ No surgeries
- ___ CABG
- ___ Knee Arthroscopy/Scope
- ___ Transplant Lung
- ___ Abdominal Surgery-type
- ___ Carotid Endarterectomy
- ___ Knee Replacement
- ___ Transplant Kidney
- ___ Aneurysm Repair
- ___ Cataract Extraction
- ___ Lumbar Discectomy
- ___ Sinus Surgery
- ___ Appendectomy
- ___ C-Section
- ___ Mastectomy
- ___ Uterus/Ovary Surgery
- ___ Left Aortic-Femoral Bypass
- ___ Cervical Discectomy
- ___ Mitral Valve Replacement
- ___ Vasectomy
- ___ Right Aortic-Femoral Bypass
- ___ Cholecystectomy
- ___ Nephrectomy
- ___ Surgery Complications
- ___ Bilateral A-F Bypass
- ___ Colon Resection
- ___ Stent Placement
- ___ ___ Yes ___ No
- ___ Aortic Valve
- ___ Craniotomy
- ___ Lung Resection
- ___ Anesthesia Complications
- ___ Breast Augmentation
- ___ Gastric Lap Band
- ___ Prostatectomy
- ___ Yes ___ No ___ Other
- ___ Breast Lumpectomy
- ___ Cryosurgery/Cryotherapy
- ___ Rotator Cuff Re
- ___ Other
- ___ Breast Reduction
- ___ Hernia Repair – Inguinal
- ___ Tonsillectomy
- ___ Bronchoscopy
- ___ Hernia Repair- Umbilical
- ___ Tubal Ligation
- ___ Cardiac/ Heart Cath
- ___ Hip Replacement
- ___ Transplant Heart
- ___ Carpal Tunnel
- ___ Hysterectomy w/BSO
- ___ Transplant Liver

Please list any surgeries not included:

_____________________________________________________________________________________________________________________________ ____________________
_______________________________________________________________________________________________________________ __________________________________
_____________________________________________________________________________________________________________________________ ____________________
_________________________________________________________________________________________________________________________________________________
**Family History:**

Has any blood relative (father, mother, siblings, grandparents, aunts or uncle or other) had any of the following? If so, please list who next to problem.

- Alcoholism
- Allergies
- Anxiety
- Asthma
- Autoimmune
- Blood Clots
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Colon Polyp
- Migraine
- Prostate Cancer
- Stroke
- Depression
- Diabetes
- Cholesterol
- Heart Disease
- High Blood Pressure
- Liver Disease
- Lung Cancer
- Melanoma
- Osteoporosis
- Seizures
- Other
- NEGATIVE FAMILY HISTORY

**Social History**

Marital Status (circle one): Single Married Divorced How many children do you have? __________

Who do you live with? ________________________________________________________________

What is your occupation? _____________________________________________________________

How many years of education do you have? __________________________________________________________________________

Do you have home health? If so, please list name of company. ______________________________________________________________________

**Risk Factors**

Tobacco Use: Yes___ No___ Current: Yes___ No___ Year started______ Packs/Day______ Cigars/week______

Year Quit: ______________ Smokless cans/day________

Alcohol Use: Yes___ No___ Drinks/day______ Type________

Drug Use: Yes___ No___ Type/Frequency________________________________________________________

Caffeine Use (circle one) Rare Sometimes Heavy

Exercise (circle one) Never Some days Most days Daily

Seatbelt Use (circle one) Never Sometimes Always

Sun Exposure (circle one) Remote Rarely Occasionally Frequently

Heart Attack in Father before age 55 Yes___ No___

Heart Attack in Mother before age 65 Yes___ No___
Preventative Care:
We strongly believe that prevention is the key to keeping you happy and healthy. We closely follow national recommendations in screening for cancer, heart disease, cholesterol problems, diabetes, high blood pressure, osteoporosis, and many vaccine preventable diseases.

In order to help us with our goal please also fill out the following.

When was your last physical exam or well woman exam? ________________________________________________

<table>
<thead>
<tr>
<th>Cholesterol</th>
<th>Testicular Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had your cholesterol levels tested in the last 5 years? □ Yes □ No</td>
<td>When was your last testicular exam ________________</td>
</tr>
<tr>
<td>Normal □ High</td>
<td></td>
</tr>
<tr>
<td>If high, what was the number __________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Colon Cancer Screening (for patients over 50)</th>
<th>Prostate Cancer Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had colon cancer screening? □ Yes □ No</td>
<td>When was your last exam ________________</td>
</tr>
<tr>
<td>Colonoscopy? If so when ____________________</td>
<td>PSA? ____________________</td>
</tr>
<tr>
<td>Where ____________________</td>
<td></td>
</tr>
<tr>
<td>Sigmoidoscopy? If so when ____________________</td>
<td></td>
</tr>
<tr>
<td>Where ____________________</td>
<td></td>
</tr>
<tr>
<td>Barium Enema? If so when ____________________</td>
<td></td>
</tr>
<tr>
<td>Where ____________________</td>
<td></td>
</tr>
<tr>
<td>Hemoccult/ blood in stool? If so when ____________________</td>
<td></td>
</tr>
<tr>
<td>Where ____________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Females only</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your last tetanus vaccine ________________</td>
<td>Cervical Cancer</td>
</tr>
<tr>
<td>When was your last flu vaccine ________________</td>
<td>When was your last pap smear ________________</td>
</tr>
<tr>
<td>When was your last pneumonia vaccine ________________</td>
<td>Where ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Osteoporosis (bone thinning and weakening)</th>
<th>Mammogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your last bone mineral density ________________</td>
<td>When was your last breast exam ________________</td>
</tr>
<tr>
<td>Where ____________________</td>
<td>When was your last mammogram ________________</td>
</tr>
<tr>
<td>Do you know the results ____________________</td>
<td>Where ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Males only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testicular Cancer</td>
</tr>
<tr>
<td>When was your last testicular exam ________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prostate Cancer Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your last exam ________________</td>
</tr>
<tr>
<td>PSA? ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Females only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer</td>
</tr>
<tr>
<td>When was your last pap smear ________________</td>
</tr>
<tr>
<td>Where ____________________</td>
</tr>
<tr>
<td>Normal □ Abnormal</td>
</tr>
<tr>
<td>Have you had a hysterectomy □ Yes □ No</td>
</tr>
<tr>
<td>Have you ever been diagnosed with cervical, uterine or ovarian cancer □ Yes □ No</td>
</tr>
<tr>
<td>What type ____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mammogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>When was your last breast exam ________________</td>
</tr>
<tr>
<td>When was your last mammogram ________________</td>
</tr>
<tr>
<td>Where ____________________</td>
</tr>
</tbody>
</table>

| Normal □ Abnormal |

| Name: ____________________ |
| DOB: ____________________ |
| Date: ____________________ |
| MR#: ____________________ |