| Primary Care Doctor: | Name | Today's Date | SS# | Date of Bi | rth |
|---|--|-------------------------------|------------------------|----------------------|-------------------|
| DO YOU HAVE ANY ALLERGIES?NoYes (List please): CURRENT MEDICATIONS Please complete or provide Printed List to Staff Medication Dose Frequency How long on Med? Medication Dose | Primary Care Doctor: | Reason for | Visit? | | |
| Medication | Current problem is the result | of (check all that apply): | Work accident | auto accident | Other (describe) |
| Medication | DO YOU HAVE ANY ALLERGIES? _ | NoYes (List please): | | | |
| Medication | CURRENT MEDICATIONS Ple | ase complete or provide Prir | nted List to Staff | | |
| Medication | Medication | DoseFreque | ency How lor | ng on Med? | |
| Over The Counter Medications, Vitamins or Herbal Preparations: TOBACCO USE: (circle) Current Former Never Type: Employed (occupation) Marital Status: Single Married Divorced Separated Widowed Children? No Yes (ages:) Are you on a special diet? No Yes (please explain): Do you have a history of substance abuse? No Yes (please explain): Do you drink alcoho? No daily 1-2x/week 1-2x/month PAST MEDICAL HISTORY Please list any hospitalizations or surgery and dates: REVIEW OF SYSTEMS Please Circle All that Apply: GENERAL: Weight loss, Fevers, Chills, Sweats HEENT: Dry eyes, Red eyes, Sore throat, Dental problems PULMONARY: Shortness of breath, Wheezing, Productive cough, Coughing up blood CARDIOLOGY: Chest pain, Irregular heartbeats, Leg swelling GI: Nausea, Vomiting, Diarrhea, Constipation, Heartburn, Abdominal pain GU: Blood in urine, Unusual menstrual bleeding, Burning with urination, Discharge NEUROLOGY: Headache, Dizziness, Balance, Numbness, Tingling, Weakness, Bowel/Bladder Dysfunction MUSCULOSKELETAL: Joint stiffness, Swollen joints, Warm/red joints, Neck pain, Back pain, Arthritis HEMATOLOGY: Bruising, Bleeding, Family history bleeding/clotting problems ENDOCRINE: Skin changes, Hair changes, Heat/cold intolerance, Poor healing SKIN: Rashes, Wounds ALLERGY: Medication allergies, Material allergies, Swollen glands, Allergy to Bees | Medication | DoseFreque | ncyHow lon | g on Med? | |
| TOBACCO USE: (circle) Current Former Never Type: SOCIAL HISTORY | Medication | DoseFreque | encyHow lon | g on Med? | |
| | Over The Counter Medication | s, Vitamins or Herbal Prepar | ations: | | |
| Employed (occupation)StudentWork in home Marital Status:SingleMarriedDivorcedSeparatedWidowed Children?NoYes (ages:) Are you on a special diet?NoYes (please explain): Do you have a history of substance abuse?NoYes (please explain): Do you drink alcohol?Nodaily1-2x/week1-2x/month PAST MEDICAL HISTORY Please list any hospitalizations or surgery and dates: REVIEW OF SYSTEMSPlease Circle All that Apply: GENERAL: Weight loss, Fevers, Chills, Sweats HEENT: Dry eyes, Red eyes, Sore throat, Dental problems PULMONARY: Shortness of breath, Wheezing, Productive cough, Coughing up blood CARDIOLOGY: Chest pain, Irregular heartbeats, Leg swelling GI: Blood in urine, Unusual menstrual bleeding, Burning with urination, Discharge NEUROLOGY: Headache, Dizziness, Balance, Numbness, Tingling, Weakness, Bowel/Bladder Dysfunction MUSCULOSKELETAL: Joint stiffness, Swollen joints, Warm/red joints, Neck pain, Back pain, Arthritis HEMATOLOGY: Bruising, Bleeding, Family history bleeding/clotting problems ENDOCRINE: Skin changes, Hair changes, Heat/cold intolerance, Poor healing SKIN: Rashes, Wounds ALLERGY: Medication allergies, Material allergies, Swollen glands, Allergy to Bees | FOBACCO USE: (circle) Current | Former Never Typ | e: | | |
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| FAMILY HISTORY: Mother: Alive/Deceased (cause) Father: Alive/Deceased (cause) Sister/Brother: | EARMI V HISTORY. Matham | Alive/Deceased (sause | \ Father: Alive/D | aceased Issues |) Sister/Brother: |

*Please describe any pertinent family medical history:

Alive/Deceased (cause