Name _____ Date of Birth _____ Today's Date _____

How did you hear about us? _____

Past Medical History Please check if you have had any of the following. Please make additional comments as needed

Eyes / Ears / Nose / Throat
___ Glaucoma
___ Decreased vision
___ Deafness / Hearing loss
___ Sinus Disease
___ Allergies
Other _____
_____

Lungs
___ Asthma
___ COPD / Chronic bronchitis / Emphysema
___ Chronic cough / Shortness of breath
Other _____
_____

Heart
___ High blood pressure
___ High cholesterol
___ Palpitations / Abnormal heart rhythm
___ Angina / Chest pain
___ Heart failure
___ Anemia
___ Heart valve disease
___ Heart murmur
___ Leg pains or cramps with walking
Other _____
_____

Stomach / Bowels
___ Hepatitis
___ Gallbladder disease
___ Ulcers or reflux disease
___ Bloody or dark stools
___ Hemorrhoids / rectal pain or bleeding
___ Frequent diarrhea / constipation
Other _____
_____

Kidney / Bladder / Sexual function
___ Kidney disease or failure
___ Bladder / Kidney infections
___ Prostate problems
___ Infertility
___ Incontinence
___ Sexual function problems
Other _____
_____

Endocrine
___ Diabetes
___ Thyroid disease
Other _____
_____

Nervous System
___ Stroke
___ Seizures
___ Sleep disturbances
___ Memory loss
___ Dizziness / Vertigo
Other _____
_____

Muscles and Bones
___ Arthritis
___ Muscle Weakness
___ Gout
Other _____
_____

Skin
___ Skin cancers or abnormal moles
___ Recurrent rashes or Itching
Other _____
_____

Infections
___ HIV
___ Sexually transmitted infections
___ Tuberculosis or exposure to TB
Other _____
_____

Cancer
_____
_____

Mental Health
___ Depression
___ Anxiety
___ Suicidal thoughts or attempts
___ Drug dependence
___ Alcoholism
Other _____
_____

Women's Health

Will we be doing your gynecological care or who is your gynecologist?_____

Total pregnancies _____ full term ____ premature _____ abortions / miscarriages ____ living children _____

Have you gone through menopause and if so how many years ago? _____

Have you had any problems with breast lumps or abnormal mammograms ? _____

Last mammogram _____ Any family history of breast problems _____

Have you had any gyn problems like abnormal pap smears or abnormal bleeding? _____

_____

Last pap smear _____ Any family history of gyn problems? _____

What is your current birth control _____

Surgeries

Type of Surgery	Year	Surgeon if known

Medicines

Medicine	Dose / Strength	How often	Why taking?

Allergies to Medicines

Medicine	Type of reaction

Preventive Health

Please give date of last known immunization

Tetanus / pertussis / whooping cough _____ Prevnar _____ Pneumovax _____

Gardasil (HPV vaccine) _____ Shingrix or Zostavax (shingles vaccine) _____

Covid Vaccines brand _____ Dates _____. _____

Please give date and result if you have ever had testing for:

Cholesterol _____

Colon cancer screening (FIT, cologuard, virtual colonoscopy or colonoscopy) _____

Prostate cancer (PSA) _____

Family History

Living? Age or Age at time of death Medical problems

Mother _____

Father _____

Brothers / Sisters _____

_____

_____

_____

_____

Occupational History

Present job _____

Former work experience _____

Social History

Marital status / partner / friend _____

Are you sexually active with men, women, both or neither? _____

Name, relationship and age of anyone living with you _____

_____

Any concerns about your home situation ? _____

Do you now or have you in the past used tobacco? (cigarettes, cigars, chewing tobacco, vaping)_____

_____

How much and for how long? _____ Are you interested in quitting? _____

Do you now or have you in the past used any street drugs? _____

Marijuana _____ Cocaine _____ Heroin / opiates _____ Methamphetamine _____

_____

Regarding alcohol:

Have you ever felt that you should cut down on your drinking? Yes ___ No ___

Have people annoyed you by criticizing your drinking? Yes ___ No ___

Have you ever felt bad or guilty about your drinking? Yes ___ No ___

Have you ever had a drink first thing in the morning to steady your nerves

or to get rid of a hangover? Yes ___ No ___

Do you have a living will or a durable power of attorney? _____

Any additional information you think we should know about you? _____

_____

_____

Thank you for your patience in filling out this questionnaire!