Welcome!

Name First:_____ Last: _____Date of Birth:_____

My preferred pharmacy is:_____

Patient is a dependent, accompanied by: _____Relationship:_____

Please check all that apply. Today's office visit is for:

Preventive Medicine Services
(Age-based screening tests, physical exam, health maintenance advice, and immunizations)

- □ Well child check-up or pre-birth visit
- □ Adult wellness visit and annual physical
- □ Immunization counseling / administration
- □ Sports, school or camp physical
- □ Other preventive medicine service/benefit:

  _____

Diagnostic or Problem Based Services
(Any evaluation of a health concern/symptom or ongoing treatment and monitoring of an existing health condition or concern. Copays and deductibles will apply.)

- □ _____
- □ _____
- □ _____
- □ Review/discuss test results
- □ A referral/prescription for:_____
- □ A procedure:_____

Copayments: For most insurance plans, you will not have a copay for preventive medicine services. For most insurance plans, you will have a copay, coinsurance, or deductible for diagnostic or problem based services. If you need both types of service on the same day, we often can accommodate you. While you are here for a preventive medicine visit, if diagnostic or problem based services also occur, we must report both to your insurance company and copayments will apply to the problem-based portion of your visit**.** Depending on what type of appointment you scheduled, the doctor might not have time to fully address multiple health concerns within one visit and therefore may ask you to schedule separate appointments.

Please list each health concern and/or health condition

	Health concern/condition	Onset date	Treatments?
1			
2			
3			
4			
5			
6			
7			
8			

Immunization history and choices:

_____ fully immunized on standard schedule _____partial or delayed immunizations _____non immunized

Last tetanus booster: _____ Last flu shot:_____

- ❑ I brought an immunization record with me today
- ❑ I need to get a copy of my immunization history from a previous provider.

Please list all surgeries, significant injuries and hospitalizations

Year	Surgery, injury, or hospitalization	Where were you treated?

Sexual History

What is your gender and sexual orientation? _____

Are you sexually active? □ Yes □ No

Are you in a monogamous relationship? □ Yes □ No

How many current sexual partners? _____

How many sexual partners in your lifetime? _____

Have you ever had an STD screen? □ Yes □ No

Have you ever had an STD? □ Yes □ No

If yes, please list: _____

Please check the box if you have, or have had, any of the following.

□ Pain with sex □ Concerns about libido □ Recurrent genital infections □Impotence

□ Any genital sores, warts, or lesions □ Recurrent urinary tract infection

Any concerns regarding fertility? □ Yes □ No

Please describe your current method of birth control: _____

Women's health history

Age menses began: _____ Date of last menstrual period: _____

Age menopause began: _____ Any hormone replacement therapy? _____

Cycle length: _____ □Regular □Irregular □Painful Days of flow: _____ □Heavy □Moderate □Light

PMS symptoms ? □none □ mild □moderate □severe

Date of last PAP: _____ HPV last tested_____ □ Positive □Negative

Any history of irregular PAP? □ No □ Yes. Describe _____

List each of your pregnancies and its outcome

Year	Outcome: miscarriage, abortion, live birth of M/F, vaginal birth or c-section, etc?	Complications?

Are you pregnant? □ Yes □ No Are you lactating? □ Yes □ No Are you trying to get pregnant? □ Yes □ No

Breast Health

Please check any box that applies to you.

□ Breast surgery □ Nipple discharge □ Regular self breast exams

□ Lactation difficulty □ Breast rash □ History of breast cancer

□ Breast Lumps/nodules □ Fibrocystic changes

□ Last mammogram: _____ Abnormal findings?_____ Months spent lactating:_____

Bone Health. Please check any box that applies to you.

□ History of bone fracture □ Sedentary lifestyle □ History of eating disorders

□ Smoker □ No menses for > 1yr □ Weight < 125 lb

Family History Are you adopted? ☐ Yes ☐ No

	Current Age or	Age of Death	Significant health problems or cause of death
Father			
Mother			
Brothers/Sisters (list)	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Children (list)	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Aunts/Uncles			

Other:

Social History

Do you have adequate **shelter/housing**? ☐ Yes ☐ No Describe:_____

Please list the current members of your household. Eg. Spouse, children, roommates, pets

Name	Age	Relationship	Name	Age	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Do you feel safe in your home?	☐ Yes	☐ No	Does anyone smoke in your home?	☐ Yes	☐ No
Does your home have lead paint?	☐ Yes	☐ No	Is there violence or abuse at home?	☐ Yes	☐ No
Is your home moldy?	☐ Yes	☐ No	Is there a gun in your home?	☐ Yes	☐ No

Work and Education

Current Occupation: _____ Previous Occupations:_____

Educational background:_____

How many hours a week do you work? _____ How many days a week do you work? _____

Do you work primarily ☐ inside or ☐ outside the home?

Do you spend more than half of your day at a desk or computer?	☐ Yes	☐ No
Do you take vacations?	☐ Yes	☐ No
Are you happy in your work?	☐ Yes	☐ No

Alcohol Intake

Do you drink alcohol?	☐ Yes	☐ No
Do you feel you drink too much?	☐ Yes	☐ No
Are you prone to binge drinking?	☐ Yes	☐ No
Do you drive after drinking?	☐ Yes	☐ No

How many drinks/week? _____

Have you ever experienced blackouts?	☐ Yes	☐ No
Do you feel guilty about your drinking?	☐ Yes	☐ No

Tobacco

Do you currently use tobacco? ☐ Yes ☐ No Did you previously use tobacco? ☐ Yes ☐ No

Please check the box that applies to you.

☐ Cigarettes ___ packs/day ☐ Chew ___ times/day ☐ Pipe___ times/day ☐ Cigars ___ times/day

In what year did you begin using tobacco? _____ In what year did you quit? _____

Drug Use

Do you use recreational or street drugs? ☐ No ☐ Yes, _____

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Please list any known allergies.

Drug Allergy:	Food Allergy:	Environmental Allergy:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all of your medications and supplements:

Medication/supplement	Dosage/ frequency	Reason for taking	Who prescribes it?	Year started

Nutrition and Exercise:

I would describe my nutrition as (circle any that apply):

Poor Fair Good Excellent

Standard American Whole Foods Natural Organic

Vegan Vegetarian Omnivore Paleo Low Carb

Other description of your nutrition:_____

Foods you avoid:_____

Please list your current body weight: _____ Height _____

What is the most _____ and least _____ that you have weighed as an adult (excluding pregnancy)?

Are you dieting to lose weight? □ Yes □ No

Do you take medications, herbs, or supplements to promote weight loss? □ Yes □ No

Do you have, or have you ever had, an eating disorder? □ No □ Binging □ Purging □ Avoidance of food

How many servings of caffeine per day? _____ In what form?_____

How often do you exercise? _____ What type of exercise do you do?_____

After moderate or vigorous exercise, how do you feel? □ Great □ Drained

Please indicate if you are experiencing any of the following:

General symptoms
- ❑ Weight loss / gain
- ❑ Fever/chills
- ❑ Weakness
- ❑ Fatigue
- ❑ Sweating/night sweats
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Hair/nail changes

Muscle/Joint/Bone symptoms
- ❑ Numbness
- ❑ Swelling
- ❑ Head / Face pain
- ❑ Neck or back pain
- ❑ Shoulder, arm, or hand pain
- ❑ Hip, leg or foot pain
- ❑ Jaw pain/TMJ
- ❑ Arthritis/joint pain
- ❑ Injury to:
- ❑ **None of the above**

Eye Symptoms
- ❑ Glasses/contacts
- ❑ Visual disturbance
- ❑ Pain or itching
- ❑ Light aversion
- ❑ Discharge
- ❑ Glaucoma/Cataracts
- ❑ **None of the above**

Ears, Nose, Throat, or Mouth symptoms
- ❑ Ringing in ears
- ❑ Ear pain or discharge
- ❑ Loss of hearing
- ❑ Sinus pain
- ❑ Nose bleeds
- ❑ Runny nose
- ❑ Congestion
- ❑ Postnasal drip
- ❑ Nasal polyps
- ❑ Throat Pain
- ❑ Mouth Sores
- ❑ Bleeding gums
- ❑ Dental problems
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Altered Taste
- ❑ **None of the above**

Heart and lung symptoms
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough/Sputum
- ❑ High or low blood pressure
- ❑ Irregular heartbeat
- ❑ Murmur
- ❑ Calf pain with walking
- ❑ Edema/ swelling
- ❑ Palpitations
- ❑ Chest pain
- ❑ Varicose veins
- ❑ **None of the above**

Gastrointestinal symptoms:
- ❑ Poor appetite
- ❑ Constipation / diarrhea
- ❑ Indigestion/heartburn
- ❑ Gas/bloating
- ❑ Bowel changes
- ❑ Abdominal pain
- ❑ Nausea or vomiting
- ❑ Hemorrhoids / anal pain
- ❑ Blood in stool
- ❑ Hernia
- ❑ **None of the above**

Genitourinary symptoms
- ❑ Low back pain
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Frequent/urgent urination
- ❑ Loss of bladder control
- ❑ Nighttime urination
- ❑ Recurrent infections
- ❑ Infertility
- ❑ Painful intercourse
- ❑ **None of the above**

Male Only symptoms
- ❑ Erection difficulties
- ❑ Lump/pain in testicles
- ❑ Penis discharge
- ❑ Sores on penis
- ❑ Breast lumps
- ❑ **none**

Female Only symptoms
- ❑ Breast lumps
- ❑ Nipple discharge
- ❑ Irregular menses
- ❑ Fibroids or heavy bleeding
- ❑ Vaginal discharge/odor/itch
- ❑ Abnormal PAP
- ❑ LMP_____
- ❑ **none**

Skin symptoms
- ❑ Itching/Rashes
- ❑ Easy bruising
- ❑ Hives
- ❑ Skin discoloration/changes
- ❑ Eczema/psoriasis
- ❑ Change in moles
- ❑ Sores that won't heal
- ❑ **None of the above**

Neurological/psychological
- ❑ Fainting
- ❑ Convulsions
- ❑ Altered Sensations
- ❑ Abnormal gait / coordination
- ❑ Speech difficulty
- ❑ Numbness/tingling
- ❑ Paralysis/weakness
- ❑ Memory loss
- ❑ Sleep problems
- ❑ Anxiety/depression
- ❑ Phobias
- ❑ Substance abuse
- ❑ Problem drinking
- ❑ **None of the above**

Endocrine symptoms
- ❑ Goiter
- ❑ Heat/cold intolerance
- ❑ Excessive thirst/hunger
- ❑ Hot Flashes
- ❑ **None of the above**

Blood/Lymphatic symptoms
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Lymph node enlargement
- ❑ Lymph node pain
- ❑ **None of the above**

Other
- ❑ _____
- ❑ _____

Office use only:

Office use only: TSFF: _____min ROS reviewed by: _____ cpCPTs:_____ NCP YCP ROC:_____