

**Welcome!**

Name First: \_\_\_\_\_ Last: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

My preferred pharmacy is: \_\_\_\_\_

Patient is a dependent, accompanied by: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Copayments and Deductibles:** For most insurance plans, you will not have a copay if the visit is for preventive medicine services only. When the need arises to address a health concern on the same day as a preventive medicine visit, we do our best to accommodate both, as we strive to provide a holistic approach to your care. ***While you are here for a preventive medicine visit, if time is spent addressing a health concern, we are required to document it in the chart and report it on the claim we submit to your insurance company. Depending on your insurance plan, copayments and deductibles may apply to that portion of your visit.*** Sometimes the doctor will not have time to address multiple health goals or concerns within one visit, and therefore may ask you to schedule a separate appointment on another day.

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

**Preventive Medicine Services\***

\*Includes a physical exam along with age-based screenings, health maintenance advice, immunizations, and assessments of growth/development as defined by the Affordable Care Act.

- Well child check-up
- Annual adult preventive medicine visit
- Immunization administration
- Sports, school, or camp physical

**Health Concerns / Regular Office Visit\*\***

\*\*Diagnostic or problem based services are 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: \_\_\_\_\_

**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)	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
Children (list)	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Other:

Name:

Date:

### 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 trying to lose or gain 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

Name:

Date:

**NO SYMPTOMS IN ANY OF THE FOLLOWING BODY AREAS**

Please indicate if you are experiencing any of the following today:

**General symptoms**

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

**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: \_\_\_\_\_

**Eye Symptoms**

- Visual disturbance
- Eye pain or itching
- Light aversion
- Discharge
- Glaucoma/Cataracts

**Ears, Nose, Throat, or Mouth symptoms**

- Ringing in ears
- Ear pain
- Ear 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

**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

**Gastrointestinal symptoms:**

- Poor appetite
- Constipation / diarrhea
- Indigestion/heartburn
- Gas/bloating
- Bowel changes
- Abdominal pain
- Nausea or vomiting
- Hemorrhoids / anal pain
- Blood in stool
- Hernia

**Genitourinary symptoms**

- Low back pain
- Painful urination
- Blood in urine
- Frequent/urgent urination
- Loss of bladder control
- Nighttime urination
- Recurrent infections
- Infertility
- Painful intercourse

**Male Only symptoms**

- Erection difficulties
- Lump/pain in testicles
- Penis discharge
- Sores on penis
- Breast lumps

**Female Only symptoms**

- Breast lumps
- Nipple discharge
- Irregular menses
- Fibroids or heavy bleeding
- Vaginal discharge/odor/itch
- Abnormal PAP
- Last period:** \_\_\_\_\_

**Skin symptoms**

- Rash: \_\_\_\_\_
- Easy bruising
- Itching or hives
- Skin discoloration/changes
- Eczema/psoriasis
- Change in moles
- Sores that won't heal

**Neurological/psychological**

- Fainting
- Convulsions
- Altered Sensations
- Abnormal gait / coordination
- Speech difficulty
- Numbness/tingling
- Paralysis/weakness
- Memory loss
- Sleep problems
- Anxiety/depression
- Phobias
- Problem drinking / drug abuse
- Addiction

**Endocrine symptoms**

- Goiter
- Heat/cold intolerance
- Excessive thirst/hunger
- Hot Flashes

**Blood/Lymphatic symptoms**

- Anemia
- Bleeding tendency
- Lymph node enlargement
- Lymph node pain

**OTHER SYMPTOMS or CONDITIONS:**

- \_\_\_\_\_
- \_\_\_\_\_

Office use only:

Office use only: TSFF: \_\_\_\_\_ min ROS reviewed by: \_\_\_\_\_ cpCPTs: \_\_\_\_\_ NCP YCP ROC: \_\_\_\_\_

Name:

Date: