Patient's Full Name: _____ **Date of Birth:** _____

Past Surgical History: (Please check all that apply and include the date)

	Date		Date		Date
□ Appendectomy		□ Hernia Repair		□ Shoulder Surgery	
□ Back Surgery		□ Hysterectomy		□ Sinus Surgery	
□ Breast Surgery		□ Hip Surgery		□ Tonsillectomy	
□ Cataract Surgery		□ Knee Surgery		□ Thyroid Surgery	
□ C-Section		□ Laparoscopy		□ Vasectomy	
□ Colonoscopy		□ Pacemaker Placement		□ Wisdom Teeth	
□ Cosmetic Surgery		□ Prostrate Surgery		□ Other:	

Family History: (Please check all that apply)

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandfather
Alcoholism	□	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□	□
Bleeding disorder	□	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□	□
Deceased	□	□	□	□	□	□	□	□
Depression	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Drug Abuse	□	□	□	□	□	□	□	□
Epilepsy	□	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□	□	□
Migraines	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□
Suicide	□	□	□	□	□	□	□	□
Thyroid Problems	□	□	□	□	□	□	□	□

Please list any other family medical history: _____

_____

Prevention Information:

	Yes	No		Yes	No
Do you use seat belts	□	□	Do you have a living will?	□	□
Do you have smoke detectors in your home?	□	□	Do you practice a healthy diet?	□	□
Do you have a loaded firearm in your home?	□	□	Do you keep a gun at home?	□	□
If yes, how is it stored?	□	□	Is it locked?	□	□
Do you use sunscreen?	□	□			

Please list any vaccine history: _____

_____

Patient's Full Name: _____ **Date of Birth:** _____

Social/Lifestyle History:

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

If married, spouse's name: _____

Children(s) names and age(s): _____

What is your occupation: _____

What are your hobbies: _____

Who lives at home with you: _____

Where were you born and raised: _____

How long have you been in this area: _____

Do you drive an automobile: _____ Do you ride a motorcycle/bicycle: _____

Do you wear a helmet: _____

Do you currently smoke or use nicotine products: _____ If yes, for how many years: _____

Are you a former smoker: _____ If yes, when did you quit: _____

Cigarettes (#Packs/day): _____ Cigars: _____ Pipe: _____ Chew Tobacco: _____

Have you ever used recreational drugs: _____ If yes, when was the last time: _____

What kind did you use: _____

Do you take over-the counter medication such as aspirin, antacids, vitamins, herbal products: _____

If yes, which ones and how often: _____

Do you take something to help you sleep: _____ If yes, what and how often: _____

Do you restrict your diet in any way? _____ If yes, how: _____

Do you drink alcohol: ☐ Never ☐ Occasionally ☐ Daily

If yes, how many days per week do you drink alcohol: _____

On a typical day when you drink how many drinks do you have: _____

Do you drink caffeine: _____ If yes, how much: _____

Have you ever worked with chemicals, paints, asbestos, or any hazardous material?: _____

If yes, what kind: _____

Patient's Full Name: _____ **Date of Birth:** _____

Review of Symptoms:

Birth Sex:_□ Male □ Female

Gender Identity: □ Male □ Female ☐ Female-To-Male/Transgender Male ☐ Male-To-Female/Transgender Female

□ Non-Binary □ Choose not to disclose □ Other, please specify: _____

Preferred Pronoun: _____

Sexual Orientation: □ Heterosexual □ Homosexual ☐ Bisexual ☐ Don't know ☐ Choose not to disclose

Medication allergies: ☐ Yes ☐ No If yes, specify: _____

Please check any symptoms you are experiencing today.

Systemic Symptoms	□ fatigue □ fever/chills □ weight change
Head Related	□ headache □ facial pain
Eye	□ trouble with vision □ pain □ redness □ light sensitivity
Ear-Nose-Throat-Mouth	□ earache □ pressure □ ringing □ TMJ □ runny nose □ nose bleeds □ post nasal drip □ sneezing □ snoring □ sore throat □ itchy throat □ hoarseness □ mouth sores □ dryness □ trouble swallowing
Neck	□ swollen glands □ pain □ muscle tightness
Respiratory	□ cough □ wheezing □ shortness of breath
Cardiovascular	□ chest pain □ palpitations □ irregular heart rate □ edema □ fast heart rate
Gastrointestinal	□ abdominal pain □ heartburn □ nausea □ vomiting □ diarrhea □ constipation □ blood in stool □ change of bowel habits
Urinary	□ pain □ frequency □ blood in urine
Skin	□ rash □ lesions □ abnormal hair loss
Musculoskeletal	□ joint pain □ back pain □ muscle pain ☐ restless legs
Neurological	□ fainting □ numbness □ dizziness
Psychological	□ insomnia □ depression □ anxious □ irritable □ generally not having fun in life
Male	□ slow urine flow □ low libido □ erectile dysfunction
Female	□ pelvic pain □ PMS □ vaginal discharge □ abnormal bleeding Date of last period: _____ Date of last pap: _____ Period lasts _____ days. Period comes every _____ days. # of pregnancies _____ # of births _____ Current method of birth control: _____
Date of last tetanus shot	

Other additional comments: _____

_____

Patient's Full Name: _____ Date of Birth: _____

Current Medications: (Please include all prescribed, over-the-counter, vitamins, herbal medication/supplements)

Medicine	Dose	Frequency