**DATE**___________________**NAME**______________________________________________**AGE**__________**SEX**__________

**DOB**_____________ **RELATIONSHIP STATUS S M D W SEP DP** **CURRENT OCCUPATION**___________________

**MEDICATIONS: NAME/DOSE/STRENGTH/TIMES PER DAY OR ATTACH LIST**

1_____________________________________________
2_____________________________________________
3_____________________________________________
4_____________________________________________
5_____________________________________________
6_____________________________________________
7_____________________________________________
8_____________________________________________
10____________________________________________
11____________________________________________
12____________________________________________
13____________________________________________

**IN THE LAST TWO YEARS HOSPITALIZATION, SURGERIES WITH DATES**

1_____________________________________________
2_____________________________________________
3_____________________________________________
4_____________________________________________

**Other Doctors/Healthcare Providers you see regularly:**

1_____________________________________________
2_____________________________________________
3_____________________________________________
4_____________________________________________

**END OF LIFE PLANNING:**

Do you have a Living Will or Advance Directive? ___Y___N

**PREVENTATIVE**: **(SINCE LAST PHYSICAL)**

IMMUNIZATIONS: (PLEASE PROVIDE DATES)

CURRENT FLU SHOT_______________________
HEPATITIS______________________________
PNEUMONIA VACCINE_____________________
TETANUS BOOSTER/T-DAP__________________
ZOSTAVAX (SHINGLES)____________________

PROCEDURES: (PLEASE PROVIDE DATES)

COLONOSCOPY_____________________________
MAMMOGRAM (FEMALE)______________________
BONE DENSITY SCAN_______________________
EYE EXAM/GLAUCOMA SCREENING______________
DERMATOLOGY (SKIN) EVALUATION_____________

| | LIVING/AGE | HEALTH PROBLEMS | DECEASED: AGE & CAUSE |
|---|---|---|---|
| MOTHER | | | |
| FATHER | | | |
| SISTER(S) | | | |
| BROTHER(S) | | | |
| | | | |

SMOKING/ALCOHOL/RECREATIONAL AND ILLEGAL DRUG USE:

| DO YOU SMOKE AT ALL OR USE SMOKELESS TOBACCO?<br>IF YES: PACKS PER DAY? | **Y** | **N** |
|---|---|---|
| ARE YOU INTERESTED IN QUITTING? | | |
| DO YOU DRINK ALCOHOL?<br>IF YES: HOW MUCH?<br>DAY____OR WEEK___ | **Y** | **N** |
| DO YOU THINK THIS IS A PROBLEM? | **Y** | **N** |
| DO YOU USE ILLEGAL/RECREATIONAL DRUGS? | **Y** | **N** |

**Are you on Oxygen? (YES) (NO)**

If yes: How many liters? _______________________
Are you on a night time only?____________________

**Are you on CPAP? (YES) (NO)**

If yes: What is your pressure setting?_____________

**Date reviewed with patient**_____________________

**Signature**____________________________________

**CONSTITUTIONAL:**

| | | |
|---|---|---|
| UNEXPLAINED WEIGHT LOSS | Y | N |
| UNEXPLAINED WEAKNESS | Y | N |
| FATIGUE | Y | N |
| FEVER SWEATS | Y | N |

**DERMATOLOGY:**

| | | |
|---|---|---|
| RASH/HIVES | Y | N |
| NEW OR CHANGING MOLE/LESIONS | Y | N |

**OPHTHALMOLOGY:**

| | | |
|---|---|---|
| DOUBLE VISION | Y | N |
| BLURRED VISION | Y | N |
| EYE PAIN | Y | N |

**ENT (EARS, NOSE AND THROAT):**

| | | |
|---|---|---|
| DECREASED HEARING | Y | N |
| RINGING (TINNITUS)/VERTIGO (DIZZINESS) | Y | N |
| HAYFEVER | Y | N |
| SINUS SYMPTOMS | Y | N |
| SORE THROAT | Y | N |

**RESPIRATORY:**

| | | |
|---|---|---|
| ASTHMA/WHEEZING | Y | N |
| COUGH/COUGHING UP BLOOD | Y | N |
| PAIN WITH BREATHING | Y | N |
| SHORTNESS OF BREATH | Y | N |
| SNORING/SLEEP PROBLEMS | Y | N |

**CARDIOLOGY:**

| | | |
|---|---|---|
| CHEST PAIN, PRESSURE OR DISCOMFORT | Y | N |
| SHORTNESS OF BREATH W/ACTIVITY | Y | N |
| PALPITATIONS | Y | N |
| DECREASE IN EXERCISE TOLERANCE | Y | N |

**GASTROINTESTINAL:**

| | | |
|---|---|---|
| CHANGE IN BOWEL MOVEMENTS | Y | N |
| DIARRHEA/CONSTIPATION | Y | N |
| RECTAL BLEEDING/HEMORRHOID SYMPTOM | Y | N |
| ABDOMINAL PAIN | Y | N |
| NAUSEA/VOMITING | Y | N |
| HEARTBURN/REFLUX/TROUBLE SWALLOWING | Y | N |

**GENITAL/URINARY:**

| | | |
|---|---|---|
| PAINFUL OR BLOODY URINATION | Y | N |
| URINATION URGENCY | Y | N |
| INCONTINENCE (LEAKAGE) | Y | N |
| DISCHARGE (PENILE OR VAGINAL) | Y | N |

**MUSCULOSKELETAL:**

| | | |
|---|---|---|
| MUSCLE PAIN/WEAKNESS | Y | N |
| JOINT PAIN/SWELLING | Y | N |
| BACK PAIN | Y | N |
| LEG CRAMPS | Y | N |
| GOUT | Y | N |

**NEUROLOGY:**

| | | |
|---|---|---|
| HEADACHES | Y | N |
| FAINTING/NEAR FAINTING | Y | N |
| LOSS OF BALANCE | Y | N |
| SEIZURES | Y | N |
| MEMORY PROBLEMS | Y | N |
| NUMBNESS/TINGLING | Y | N |

**HEMATOLOGY:**

| | | |
|---|---|---|
| ABNORMAL BRUISING/BLEEDING | Y | N |
| SWOLLEN LYMPH NODES/GLANDS | Y | N |

**WOMEN:**

| | | |
|---|---|---|
| ABNORMAL PERIOD | Y | N |
| VAGINAL BLEEDING AFTER MENOPAUSE | Y | N |
| HOT FLASHES | Y | N |
| BREAST MASS/LUMPS | Y | N |

**MEN:**

| | | |
|---|---|---|
| DECREASED LIBIDO | Y | N |
| E.D. | Y | N |
| HERNIA | Y | N |
| SLOW STREAM/FREQUENT URINATION | Y | N |

**ENDOCRINOLOGY:**

| | | |
|---|---|---|
| COLD/HEAT TOLERANCE | Y | N |
| INCREASED THIRST | Y | N |
| INCREASED URINATION | Y | N |

**PSYCHOLOGY/STRESS:**

| | | |
|---|---|---|
| LIFE IS GOING WELL | Y | N |
| DO YOU FEEL ANXIOUS, DEPRESSED OR SAD | Y | N |
| DO YOU HAVE SUPPORT OF FAMILY/FRIENDS IN TIME OF NEED | Y | N |
| DO YOU HAVE INSOMNIA/SLEEP PROBLEMS | Y | N |
| DOES YOUR HEALTH LIMIT YOUR SOCIAL ACTIVITY | Y | N |
| DO YOU FEEL LITTLE INTEREST OR PLEASURE IN DOING THINGS? | Y | N |
| FEELING DOWN, DEPRESSED OR HOPELESS? | Y | N |

**GENERAL HEALTH:**

| | | |
|---|---|---|
| DO YOU WEAR A SEAT BELT? | Y | N |
| DO YOU FEEL YOU ARE IN GOOD HEALTH? | Y | N |
| ARE YOU CONFIDENT MANAGING YOUR HEALTHCARE? | Y | N |
| ARE YOU IN PAIN?<br>IF YES: MILD MODERATE SEVERE | Y | N |

**EXERCISE:**

| | | |
|---|---|---|
| DO YOU EXERCISE REGULARLY?<br>IF YES: HOW MANY DAYS/WEEK?<br>HOW MANY MINUTES? | Y | N |

**NUTRITION:**

| | | |
|---|---|---|
| DO YOU EAT FRUITS/VEGETABLES REGULARLY? | Y | N |
| DO YOU EAT WHOLE GRAINS DAILY? | Y | N |
| DO YOU EAT JUNK FOOD DAILY? | Y | N |