NAME:____AGE:__________
DOB:____HOME PHONE:__________
DATE:____WORK PHONE:__________

ARE THERE ANY OTHER PHYSICIANS INVOLVED IN THEIR/YOUR CARE

ATTENDING PHYSICIAN:____

CONSULTING PHYSICIAN:____

ORTHOPEDIST:____

CARDIOLOGIST:____

NEUROLOGIST:____

OPTHALMOLOGIST:____

PLEASE DESCRIBE THE RECENT EVENTS WHICH HAVE RESULTED IN THIS VISIT:

____

____

____

____

____

____

PAST MEDICAL HISTORY: (Please indicate which, if any, of the listed medical problems are present and any pertinent details such as dates, location, and physicians involved)

ASTHMA____
EMPHYSEMA____
BRONCHITIS____
HIGH BLOOD SUGAR____
HEART ATTACK____
STROKE____
DIABETES____
ULCERS____
BOWEL PROBLEMS____
URINARY PROBLEMS____
ARTHRITIS____
JOINT OR BONE PROBLEM____
____
____
____

DEPRESSION____
DEMENTIA/ALZHEIMERS____
OTHER____
____

PAST SURGICAL HISTORY: (Please indicate which, if any, of the listed surgical procedures were performed and any pertinent details such as dates, location, and physicians involved.)

HEART BYPASS OR BALLOON

GALL BLADDER REMOVAL

HYSTERECTOMY

APPENDECTOMY

BONE SURGERY

OTHER

MEDICATIONS (Please indicate the name of the medicine, the strength, how often you receive it and how it is received or applied.)

ALLERGIES (Please indicate the name of the allergic substance and how you are affected)

IMMUNIZATIONS (When was the last time, if ever, the following immunizations or tests were done)
TETANUS_______________
PNEUMONIA VACCINE_______________
FLU VACCINE_______________
MAMMOGRAM_______________
PAP SMEAR_______________
COLONOSCOPY OR FLEXIBLE SIGMOIDOSCOPY_______________
BONE DENSITY SCAN_______________

FAMILY HISTORY (Is Mom and Dad, Brothers/Sisters alive or have they died/Please indicate age and health problems

____
____
____
____
____

SOCIAL HISTORY
WHAT TYPE OF WORK ARE YOU INVOLVED IN_______________
____
MARRIED, SINGLE, DIVORCED OR WIDOWED_______________
DID YOU SMOKE/HOW MUCH/HOW LONG_______________
DID YOU DRINK ALCOHOL/HOW MUCH PER DAY FOR HOW LONG_______________
____
WAS THERE ANY DRUG DEPENDANCE_______________
____
NEXT OF KIN OR POWER OF ATTORNEY (Please list name, relationship and phone number)_______________
____
REVIEW OF SYSTEMS (Any problems with any of the below over the last couple of days)
EATING _______________
DRINKING_______________
BREATHING_______________
CHEST PAIN_______________
PASSING URINE_______________
PASSING STOOL_______________
FEVER/CHILLS_______________
WEIGHT CHANGES_______________
BLEEDING_______________
MOVING JOINT/LIMBS/BACK_______________
CHANGES IN MOOD OR DEPRESSION_______________

CURRENT WEIGHT_______________
CURRENT HEIGHT_______________

Thank you for taking your valuable time to fill this out. It means so much in providing good care and it is truly appreciated.