

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Last Physical Exam (est.): \_\_\_\_\_ Chief Complaint Today: \_\_\_\_\_

Do you have a physician outside our facility? \_\_\_\_\_ If yes, what is their name? \_\_\_\_\_

**Do you currently have or have had problems with the following symptoms in the past 12 months?**

✓ Check all boxes that apply

<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Depression	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Back Trouble	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Sinus
<input type="checkbox"/> Balance/ Coordination	<input type="checkbox"/> Ears/Hearing	<input type="checkbox"/> Mole Changes	<input type="checkbox"/> Skin Infections
<input type="checkbox"/> Blackouts/Fainting	<input type="checkbox"/> Eyes/Vision	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Bleeding/Bruising	<input type="checkbox"/> Excessive Fatigue	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Sleep Changes
<input type="checkbox"/> Bowel Changes	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Nervousness/Anxiety	<input type="checkbox"/> Stomach/Indigestion
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Fever/Sweats/Chills	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Throat
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Confusion	<input type="checkbox"/> Glands/Hormones	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Weight Gain/Loss
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sexual Difficulty	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Caffeine Use ↓ Frequency ____/Day	<input type="checkbox"/> Alcohol Use ↓ Frequency ____/Day	<input type="checkbox"/> Tobacco Use ↓ Frequency ____/Day	<input type="checkbox"/> Street Drug Use ↓ Frequency ____/Day

**FEMALE ONLY**

Abnormal Pap Smear

Bleeding Between Periods

Menstrual Pain

Painful Intercourse

**MALE ONLY**

Hot Flashes

Nipple Discharge

Vaginal Discharge

Erection Difficulties

Lump in Testicles

Penis Discharge

Prostate

Sore on Penis

**Have you or a family member ever had any of the following?**

Circle "S" for self or "F" for a Family Member (i.e. Mother, Father, Sibling, and Grandparent)

AIDS or HIV +	S	F	Eye Disease	S	F	Multiple Sclerosis	S	F
Alcoholism	S	F	Glaucoma	S	F	Osteoporosis	S	F
Arthritis	S	F	Head Injury	S	F	Pacemaker	S	F
Asthma/Allergies	S	F	Heart Disease	S	F	Parkinson Disease	S	F
Bladder Disease	S	F	Hepatitis	S	F	Psychiatric Care	S	F
Blood Disorders	S	F	High Blood Pressure	S	F	Respiratory Problems	S	F
Broken Bones	S	F	High Cholesterol	S	F	Rheumatic Fever	S	F
Bulimia	S	F	Kidney Problems	S	F	STD	S	F
Cancer	S	F	Liver Disease	S	F	Stomach Problems	S	F
Chem. Dependency	S	F	Low Blood Pressure	S	F	Stroke	S	F
Depression	S	F	Migraine Headaches	S	F	Suicide Attempt	S	F
Diabetes	S	F	Mononucleosis	S	F	Thyroid Problems	S	F
Emphysema	S	F	Muscular Dystrophy	S	F	Tuberculosis	S	F
Epilepsy	S	F						

**Please List Current Medications:** \_\_\_\_\_

**Please List All Known Allergies:** \_\_\_\_\_

**Please List Major Surgeries/Hospitalizations:** \_\_\_\_\_

**To the best of my knowledge all the information above is correct.  
I am aware it is my responsibility to update the provider of any changes.**

Signature of Patient/Guardian

Relationship to Patient

Date