

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age _____ How would you rate your general health? _____ Excellent _____ Good _____ Fair _____ Poor

Main reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS: Please check any current symptoms you have;

<i>Constitutional</i>	<i>Respiratory</i>	<i>Skin</i>
____ Recent fevers/sweats	____ Cough/wheeze	____ Rash
____ Unexplained weight loss/gain	____ Coughing up blood	____ New or changes in mole
____ Unexplained fatigue/weakness		

<i>Eyes</i>	<i>Gastrointestinal</i>	<i>Neurological</i>
____ Change in vision	____ Heartburn/reflux	____ Headaches
	____ Blood or change in bowel movement	____ Memory loss
	____ Nausea/vomiting/diarrhea	____ Fainting
	____ Pain in abdomen	

<i>Ears/Nose/Throat/Mouth</i>	<i>Genitourinary</i>	<i>Psychiatric</i>
____ Difficulty hearing/ringing in ears	____ Painful/bloody urination	____ Anxiety/stress
____ Hay fever/allergies/congestion	____ Leaking urine	____ Sleep problem
____ Trouble swallowing	____ Nighttime urination	

<i>Cardiovascular</i>	____ Discharge: penis or vagina	<i>Blood/Lymphatic</i>
____ Chest pains/discomfort	____ Unusual vaginal bleeding	____ Unexplained lumps
____ Palpitations	____ Concern with sexual functions	____ Easy bruising/bleeding

<i>Breast</i>	<i>Musculoskeletal</i>	<i>Endo</i>
____ Breast lump	____ Muscle/joint pain	____ Cold/heat intolerance
____ Nipple discharge	____ Recent back pain	____ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? __ Yes __ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g. mg/pill)	How many times per day
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Allergies or reactions to medications: _____

Date of your most recent **IMMUNIZATIONS:**

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Pneumovax(pneumonia) _____
 Meningitis _____ Tetanus (Td) _____ Varicella (chicken pox) shot or illness _____ Tdap (tetanus & pertussis) _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (Cholesterol) _____ Date _____ Abnormal? _____ Yes _____ No
 Sigmoidoscopy _____ or Colonoscopy _____ Date _____ Abnormal? _____ Yes _____ No
 Women: Mammogram _____ Date _____ Abnormal? _____ Yes _____ No Pap Smear _____ Date _____ Abnormal? _____ Yes _____ No
 Dexascan (osteoporosis) _____ - Date _____ Abnormal? _____ Yes _____ No
 Men: PSA (prostate) _____ Date _____ Abnormal? _____ Yes _____ No