Patient Name _____ DOB_____ Today's Date_____

Reason for visit What problems are we seeing you for today?

_____

_____

_____

Medications you take including all vitamins, herbs, and supplements

List all medications you take including OTC. Please do not say "see my chart"

Social History

Tobacco: □ Never □ Current (How much) _____ □ 2nd Hand □ Prior Use	Quit Date _____
Alcohol: □ Never □ Occasional □ Daily □ Past Use and Quit Date_____	What Type _____
Caffeine: □ Never □ Occasional □ Daily	
Drug Abuse: □ Never □ Occasional □ Daily □ Prior Use Quit Date_____	History of Abuse (describe) _____
Occupation: _____ Exercise type/frequency	_____
Home Environment: □ Alone □ Spouse □ Children □ Private Home □ Assisted Living □ Other	Marital Status: _____ Use Seat Belt:

Family History Use "X" to indicate positive history

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Diabetes									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depression or manic depressive disorder									
Colon or Rectal cancer									
Breast cancer									
Other cancer									
Other:_____									

Patient Name _____ **Today's Date_____**

Medical History

Hospital visits since last office visit/reason	Facility	Attending Physician	Date of hospital visit	Past surgeries (include date and description of any complications

Allergies

Allergies	**Type of reaction**

Other Physicians and Providers of Care

Name and specialty/provider type	**Type of care**	**Date Discontinued**

Review of Problems Do you have any of the following problems? □ Physician Reviewed

Weight gain or loss	**Heartburn**
Tiredness	**Stomach pain**
Sadness	**Nausea**
Not sleeping	**Diarrhea or Constipation**
Dizziness	**Knee or hip pain**
Headaches	**Tingling**
Eye or ear problems	**Urination problems**
Nose or sinus problems	**Abnormal periods**
Breast problems	**Gonorrhea or Chlamydia**
Chest pain	**Cough**
Hearing Difficulties	**Breathing problems**
Vision Difficulties	

Do you have a living will? □ Yes □ No
This is not a regular will; it is a legal document indicating whether you want artificial feeding if you are terminally ill. If you have this, we would like a copy so we know your wishes.

Do you have a Health Care Representative? □ Yes □ No
This is a legal document designating who you want to make decisions for you if you are incapacitated. It is different from a power of attorney. If you have this we would like a copy so we know your wishes.

We want to help you stay as independent as you can be. It helps us to know if you are able to take care of all of your needs, or do you need help with: □ phone □ transportation □ shopping □ preparing meals □ housework □ laundry □ medications □ managing money

We would like to prevent falls. Things you may consider are:
Do you have any rugs in the hallway? □ Yes □ No
Do you have grab bars in the bathroom? □ Yes □ No
Do you have stairs without a handrail or without good lighting? □ Yes □ No

Have you noticed any hearing difficulties? □ Yes □ No
If yes, would you like a hearing evaluation? □ Yes □ No
Do you use hearing aids? □ Yes □ No

Over the past 2 weeks have you felt down, depressed, or hopeless?	□ Yes □ No
Do you exercise regularly? □ Yes □ No	Exercise type and frequency _____
Over the past 2 weeks have you felt little interest or pleasure in doing things? □ Yes □ No	

Do you wear a seatbelt? □ Yes □ No
Date of last Colonoscopy? _____ Date of last Bone Density? _____

FOR WOMEN
Date of last Mammogram? _____
Date of Menopause?_____ Number of Pregnancies?_____