Date of appointment: ________________________

Patient name: ____ Date of birth: _________________ Age: ___________

Primary care provider: _____________________________________ Referring provider: ___________________________________

Reason for Visit: ____

****Nurse use only:***

Preferred local pharmacy: _______________________________ Preferred mail order pharmacy: _______________________

Preferred laboratory for blood work: ______________________ Preferred radiology facility: ___________________________

HT _______ Weight _______ BP ______/______ Pulse ________

Fallen within the last 3 months? ______ Fear of falling?______ Difficulty ambulating? ______

Patient Review of Systems

Please mark any condition with which you have had significant problems in the last 6 months:

Constitution

___ Chills
___ Diaphoresis (Night sweats)
___ Fatigue
___ Fever
___ ***Loss of appetite***
___ ***Weight loss***
___ ***Weight gain***

HEENT

___ Eye pain
___ Trouble swallowing
___ ***Yellow eyes***

Respiratory

___ Chronic cough
___ Shortness of breath
___ Wheezing
___ ***Excessive snoring***
___ ***Hoarseness***

Cardiovascular

___ Chest pain
___ Palpitations

Gastrointestinal

___ Abdominal distention
___ Abdominal pain
___ Blood in stool
___ Constipation
___ Diarrhea
___ Nausea
___ Vomiting
___ ***Black stool***
___ ***Change in bowel habits***
___ ***Difficulty swallowing***
___ ***Gas/flatulence***
___ ***Heartburn/indigestion***
___ ***Bowel accidents***
___ ***Reflux***
___ ***Vomiting blood***

Genitourinary

___ Pain on urination (Dysuria)
___ Flank pain
___ Blood in urine (Hematuria)

Musculoskeletal

___ Back pain
___ Arthralgia's (Joint pain)

Skin

___ Rash
___ Color changes (Yellow skin)

Neurological

___ Dizziness
___ Headaches
___ Light-headedness
___ Seizures
___ Weakness

Hematological

___ Enlarged lymph nodes (Adenopathy)
___ Bruises/bleeds easily

Psychiatric

___ Behavior problems (Depression)
___ Nervous/anxious
___ Sleep disturbances

Patient name: ____ Date of birth: ________________________

Immunizations:

	Y/N	Date last received
Flu Vaccine		
If 65 or older, Pneumococcal Vaccine		

Please update any new medications or allergies since we last saw you in our office:

Medications:

Medication Name	Dose	Frequency

Medication Allergies:

Name of allergen	Reaction/Date of Onset

Social History

Tobacco Use: Y/N/Former Quit date: _____________ Packs/day: __________

Smokeless Tobacco: Y/N/Former Type: Chew/Snuff Quit date: ___________

Alcohol use: Y/N/Former

Drinks per week: ____ glasses of wine ____ cans of beer ____ shots of liquor

Drug use: Y/N/Former

Types: ____ marijuana ____ methamphetamine ____ cocaine ____ IV

Other:

____

____

Caffeine use: Y/N/Former Amount/Day: __________ Type: ______________