

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 _____

Immunizations: Flu/When? _____ (65 or older) Pneumovax/When? _____

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

- ___ Arthralgia's (Joint pain)
- ___ Back 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: _____