Patient Name ____Gender ☐ M ☐ F

Last First Middle

Date of Birth _____/_____/__________ Social Security Number _____-_____-_______

Email Address ____________________________________

If you are completing this form on behalf of the patient:

Name______________________ Relationship_____________ Reason_______________

Reason for visit____

Patient's Address

____

____

____

Patient's phone numbers

Home_________________________________

Mobile_________________________________

Work_________________________________

Emergency Contact Address

____

____

____

Emergency Contact phone numbers

Home_________________________________

Mobile_________________________________

Work_________________________________

Insurance information

Carrier______________________________ Phone_________________________________

Policy #_____________________________ Fax___________________________________

Additional Insurance information

Carrier______________________________ Phone_________________________________

Policy #_____________________________ Fax___________________________________

Have you completed a *Living Will* OR designated a *Durable Power of Attorney for Health Care*? ☐ Yes ☐ No

If yes, please provide a copy with this form.

Do you have any religious or cultural beliefs that involve your health care? ☐ Yes ☐No

Explain____

Level of education completed:

☐ < Highschool ☐ Highschool ☐ 1-4 years of college ☐ > 4 years of college

Healthcare providers from whom you are currently receiving care (within 12 months).

Name	Phone Number	Reason for seeing

List all medications you are taking.

Medication Name	Dose	Frequency

List all allergies to foods, medications, etc.

Allergy	Type of reaction

Patient Name________________________________ DOB_____ /______/_________

Review of Symptoms:

Condition	Yes	No	Condition	Yes	No
Constitutional			**Genitourinary**		
Weight Loss or Gain			Blood in your urine		
Appetite changes (increased or decreased)			Menstrual changes		
Fatigue, profound and impairs daily function			Urinating that is painful or difficult		
Fever			Erection problems		
Shakes/sweats from lack of alcohol or drug			Vaginal discharge or bleeding		
Eyes			**Musculoskeletal**		
Eye pain or drainage			Broken bones		
Visual changes			Joint pain or swelling		
Dry, irritated eyes			Muscle aches		
ENT/Mouth			Muscle weakness		
Ear pain or drainage			Back pain		
Frequent sinus infections			**Skin/Breasts**		
Hearing changes or loss			Masses or lumps		
Nosebleeds			Nipple discharge		
Dizziness			Rashes or non healing ulcers		
Respiratory			**Neurologic**		
Blood in your sputum			Seizures		
Chest tightness			Coughing or choking with swallowing		
Cough lasting >1 month, productive or not			Excessive daytime sleepiness		
Shortness of breath			Extremity pain or burning sensations		
Wheezing			Hallucinations		
Chest pain with inhalation or coughing			Numbness or tingling		
Cardiovascular			Difficulty falling asleep, staying asleep		
Chest pain or heaviness			**Endocrinologic**		
Palpitations			Hair loss		
Fainting or near fainting spells			Frequent urination		
Swelling of feet or legs			Increased thirst		
Shortness of breath lying flat in bed			Heat or cold intolerance		
Gastrointestinal			**Heme/Lymph**		
Abdominal pain			Bleeding from gums or nose		
Blood in your stool			Unexplained bruising		
Constipation			Night Sweats		
Diarrhea or Food Intolerance			Swollen, painful lymph nOdes		
Heartburn or Indigestion			**Allergy/Immunology**		
Vomiting or nausea lasting for >1 day			Watery eyes		
Swallowing difficulty			Runny nose		
Psych			Food intolerance		
Anxiety without clear explanation			Frequent skin sores		
Sadness lasting for days or weeks			Other Symptoms? Describe:		
Hearing voices					
Thoughts of hurting yourself					
Thought of hurting others					
Fear of people, places or things					

MyMDBCS

Past Medical History and Family Medical History:

Indicate if you or a Primary Relative (biological Mother, Father, Siblings) have had any of the following conditions:

Condition	Yes	No	Fam	Condition	Yes	No	Fam
Adrenal Dysfunction				Irregular Heart Rhythm			
Alzheimer				Kyphosis			
Amyotrophic Lateral Sclerosis				Liver Dysfunction			
Anorexia or Bulimia				Kidney Failure, or Dysfunction			
Anxiety Disorder				Malignancy Cancer) If yes, describe below			
Arteriovenous Malformations (AVM)							
Arthritis							
Asthma				Mania			
Autoimmune Disease				Muscular Dystrophy			
Bipolar Disorder				Myocardial Infarction (Heart Attack)			
Bleeding Disorder				Narcolepsy			
Cataracts				Obstructive Sleep Apnea			
Cerebrovascular Accident (Stroke)				Organ Transplant If yes, describe			
Chemotherapy							
Claudication				Osteoporosis			
Clotting Disorder				Pancreatitis			
Congenital Heart Defects				Periodic Limb Movement Disorder			
Coronary Artery Disease.				Peripheral Artery Disease			
COPD				Personality Disorder			
Cystic Fibrosis				Pituitary Dysfunction			
Depression				Polycystic Ovarian Syndrome			
Diabetes				Pulmonary Artery HypertenSion			
Dialysis				Pulmonary fibrosis			
Eclampsia or Pre-eclampsia				Radiation Therapy If yes, explain			
Endocarditis							
Endometriosis				Recurrent Infections			
End Stage Renal Disease				Restless Leg Syndrome			
Erectile Dysfunction				Sarcoidosis			
Esophageal Dysfunction				Schizophrenia			
Fibromyalgia				Scleroderma			
Gallstones				Scoliosis			
Gastritis or Gastric Ulcers				Seizure Disorder			
GERD (reflux problems)				Sickle Cell			
Glaucoma				Sjogren			
Heart or Valve Defects				Skin Disorders (Psoriasis, Acne)			
Hemochromatosis				Thalassemia			
Hemorrhoids				Thrombocytopenia			
Hepatitis				Thrombophilia			
HIV or AIDS				Transfusions			
Hypertension				Tuberculosis			
Hyperthyroidism				Urinary retention or urgency			
Hypotension				Vasculitis			
Hypothyroidism				Visual defects			
Inflammatory Bowel Disease				Vocal cord dysfunction/paralysis			

Surgical Procedures

Procedure type	Approximate Date

Most recent occupations (most recent/current at top). Please include any health concerns related to your work in that job.

Occupation	# of years	Concerns

Have you traveled outside the U.S. recently?

Where?	When?	Duration?

Do you exercise? ☐ Yes ☐No If yes, please describe type, frequency and duration.

____

____

____

In the past year, have you fallen? ☐ Yes ☐ No If yes, how many times?____________

What caused the fall?____

Describe any injury as a result____

Do you have a history of **smoking**? ☐ Yes ☐ No If yes, ____ packs/day for ______ yrs

Do you currently smoke? ☐ Yes ☐ No

Have you ever smoked pipes/cigars? ☐ Yes ☐ No If yes, how many____ per ☐day☐wk

If you ever quit for a period of time, how long? _________________________

Have you tried quitting and failed? ☐ Yes ☐ No If yes, how many times? ________

Have you considered quitting? ☐ Yes ☐ No

Do you currently drink **alcohol**? ☐ Yes ☐ No If yes, ____drinks per ☐day ☐wk

Do you have a history of heavy use? ☐ Yes ☐ No

Do you need to drink to prevent shaking, irritability, sweating, etc.? ☐ Yes ☐ No

Have you ever been arrested for DUI? ☐ Yes ☐ No

When did you last drink to the point of blackout/unconsciousness? ___________________

Do you currently use **recreational drugs**? ☐ Yes ☐ No

If yes, ☐ Marijuana ☐ Cocaine ☐ Amphetamine ☐ Heroin ☐ Inhalants

☐ LSD/PCP

Method of use ☐ Ingestion ☐ Injection ☐ Smoking ☐ Snorting

Have you ever used injection drugs? ☐ Yes ☐ No

Have you ever had a problem with addiction to prescription medications? ☐ Yes ☐ No

If yes, when and which one?____

Are you currently **sexually active**? ☐ Yes ☐ No

Do you practice birth control of any kind? ☐ Yes ☐ No

☐ Condoms ☐ Diaphragm ☐ IUD ☐ Hormonal (pills, patches, implants, injection)

How many partners have you had in the past year? __________

Have you ever had sex with someone who is the same gender, bisexual, or who performs sex in exchange for money or drugs? ☐ Yes ☐ No

Have you ever been diagnosed with a sexually transmitted disease? ☐ Yes ☐ No

Which one?_______________ Did you receive medical treatment for it? ☐ Yes ☐ No

Do you have any Tattoos or Piercings? ☐ Yes ☐ No

Have you ever received a transfusion of blood or blood products? ☐ Yes ☐ No

How often do you wear a **seatbelt**? ☐ Always ☐ Sometimes ☐ Never

Do you perform your hygiene, housework, shopping, etc. independently? ☐ Yes ☐ No

If you are female, have you ever been **pregnant**? ☐ Yes ☐ No

# of pregnancies_____ # of live births _____ # of miscarriages/abortions_____

Age of onset of menstrual periods _______ Age of onset of menopause _______

Have you ever used **birth control pills**, patches, implants, shots? ☐ Yes ☐ No

If yes, for how many years total? ____________

Have you ever been on hormone replacement therapy? ☐ Yes ☐ No

If yes, what type? __________________________ How long? _____years

Did you ever have an IUD ☐ Yes ☐ No Was it removed? ☐ Yes ☐ No When?_____

Vaccines:

Vaccine	Yes	No	Year	Vaccine	Yes	No	Year
Influenza				Hepatitis A			
Pneumonia				Hepatitis B			
Tetanus				Rabies			
Varicella				Meningitis			
HPV (gardisil)							

Previous Procedures (add any procedures not listed in the blank spaces at bottom)

Procedure	Yes	No	Year	Reason for the procedure
PAP Smear				
Prostate Biopsy				
Mammogram				
Colonoscopy				
Esophageal endoscopy				
EKG				
Cardiac stress test				
Cardiac catheterization				
Echocardiogram				
Chest x-ray				
CT scan				
Pulmonary function				
EEG				
Bone density test				