PATIENT NAME: _____DOB:_____ AGE: _____

PARENT/ GUARDIAN NAME: _____PHONE#:_____

☐ *Please check if there have been any changes in information such as address, phone or insurance, since last visit.*

NAME OF INSURANCE COMPANY _____

PRIMARY CARE PHYSICIAN: _____ LOCATION: _____

☐ *I would like my visit notes to be sent to the physician listed above.*

REASON FOR TODAY'S VISIT: _____

PHARMACY OF CHOICE: _____

CURRENT MEDICATIONS: please include prescriptions, over-the-counter medications, birth control pills, etc.:
(If you have brought a list of your current medications, we will make a copy and attach it to this form)

_____

_____

ALLERGIES: List any allergies to medications or other materials *(e.g. latex).* What was the reaction?

_____

_____

CURRENT SYMPTOMS: please read the following list of symptoms and mark all of those that you are experiencing ***today*** or with ***current illness***.

CONSTITUTIONAL
- ☐ Change Of Appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Sweats
- ☐ Weight Loss

CARDIOVASCULAR
- ☐ Chest Pain/Pressure
- ☐ Fainting
- ☐ Fluttering/Palpitations

NEUROLOGICAL
- ☐ Headache
- ☐ Light Headedness
- ☐ Numbness
- ☐ Poor balance/Coordination
- ☐ Tingling
- ☐ Weakness

PSYCHIATRIC
- ☐ Anxiety/Nerves
- ☐ Depression

LYMPH
- ☐ Frequent Infections
- ☐ Lymph Nodes

EYES
- ☐ Blurred Vision
- ☐ Contact Lenses
- ☐ Double Vision
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Wear Eyeglasses

ENT
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Nasal Congestion
- ☐ Nasal Discharge
- ☐ Sneezing
- ☐ Sore Throat

RESPIRATORY
- ☐ Congestion
- ☐ Cough

MUSCULAR
- ☐ Joint/Muscle Pain
- ☐ Swelling

GI
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal/Perirectal Complaints
- ☐ Urinary/Bowel Changes
- ☐ Vomiting

GU
- ☐ Discharge
- ☐ Frequent Urination
- ☐ Nighttime Urination
- ☐ Painful Urination
- ☐ Sexual Difficulties

SKIN
- ☐ Bruising
- ☐ Itching
- ☐ Laceration
- ☐ Rash
- ☐ Redness
- ☐ Skin sore

PLEASE CONTINUE TO BACK SECTION

MEDICAL HISTORY List all past surgeries and dates:

_____

_____

SOCIAL HISTORY

Do you currently or have you in past used products such as cigarettes, cigars, pipes, or smokeless tobacco?

- ☐ Yes Which kind? _____ How much/often? _____
- ☐ No Quit Which kind? _____ When did you quit? _____
- ☐ Never

Do you consume alcohol?

- ☐ Yes How much/often? _____
- ☐ No

Do you currently or have you in the past used illegal drugs such as marijuana, cocaine, methamphetamines?

- ☐ Yes Which kind? _____ How much/often? _____
- ☐ No Quit Which kind? _____ When did you quit? _____
- ☐ Never

IMMUNIZATIONS

Have you received any of these vaccines?

- ☐ Flu Vaccine When? _____
- ☐ Tetanus When? _____
- ☐ TDap (pertussis) When? _____

Are you current on your childhood immunizations?

- ☐ Yes
- ☐ No

FAMILY HISTORY

Do ***you*** or a ***family member (***father, mother, or sibling) have a history of any of the following?

- ☐ Cardiovascular (Heart) Whom? _____
- ☐ High Cholesterol Whom? _____
- ☐ Cancer/Leukemia Whom? _____
- ☐ High Blood Pressure Whom? _____
- ☐ Brain Aneurism Whom? _____
- ☐ Diabetes Whom? _____
- ☐ Alzheimer's Whom? _____
- ☐ Psychiatric (Depression, Bipolar, etc.) Whom? _____