



Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Previous Last Name(s): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

**MEDICATIONS**

Please include prescription and non-prescription medications used on a regular basis (Including aspirin, vitamins, laxatives, birth-control, injections, alternative medicines, etc.) Add extra sheet if needed.

Name:	Dose:	Frequency:	Used for:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGIES/SENSITIVITIES**

Drug or Substance:	Reaction:	When:
_____	_____	_____
_____	_____	_____

**PERSONAL & FAMILY HEALTH HISTORY**

	Self	Mother	Father	Sibling		Self	Mother	Father	Sibling
Surgeries					Colon/Bowel Disease				
Heart Disease					Fibromyalgia				
High Cholesterol					History of Blood Clots				
High Blood Pressure					Osteoporosis				
Stroke					Anemia				
Cancer					Bleeding Disorder				
Diabetes					Depression				
Thyroid Problem					Anxiety				
Asthma					Alcohol Problem				
Emphysema					Substance/Drug Problem				
Allergies					Seizures				
Gout					Migraines				
Arthritis					Glaucoma/Eye Disease				
Kidney Disease/Stones					Major Accident				
Liver Disease/Hepatitis					Blood Transfusion				
Ulcer					Recurrent Back Pain				
Heartburn/GERD					Orthopedic Problems				
Gynecological Problems					Skin Disease				

Explanation of any checked that pertain to you:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY**

Current Marital Status: Single  Married  Separated  Divorced  Widowed   
 Do you smoke cigarettes?  Yes  No If yes, how many per day? \_\_\_\_\_  
 Do you chew tobacco?  Yes  No If yes, how much per day? \_\_\_\_\_  
 Did you smoke in the past?  Yes  No If yes, date you quit: \_\_\_\_\_  
 Do you consume alcohol?  Yes  No  
 If yes, what? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_  
 Has anyone ever expressed concern about your drinking?  Yes  No  
 Do you often drink alone?  Yes  No  
 Is alcohol a factor in any problems you may have experienced (personal, employment, legal)?  Yes  No  
 Do you feel your overall health would be better if you stopped drinking?  Yes  No  
 Would you like more information or help with quitting drinking?  Yes  No  
 Do you drink coffee, tea, or soda containing caffeine?  Yes  No How much daily? \_\_\_\_\_  
 Do you or have you used recreational drugs?  Yes  No If yes, what kind and how much? \_\_\_\_\_  
 Do you exercise regularly?  Yes  No If yes, how and how often? \_\_\_\_\_  
 Current Occupation: \_\_\_\_\_ Current Employer: \_\_\_\_\_  
 Hobbies: \_\_\_\_\_  
 Do you follow any special diet?  Yes  No Type: \_\_\_\_\_  
 Military History: \_\_\_\_\_ Religion: \_\_\_\_\_  
 Sexual Orientation: \_\_\_\_\_ Birthplace: \_\_\_\_\_  
 Highest Education Level: Elem  HS  College  Grad-Degree

**HOUSEHOLD MEMBERS**

Name	Age	Relationship	Any major changes in your family/personal life?
1. _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

**IMMUNIZATION STATUS**

Have you had?	Date of last	Results	Have you had?	Date of last	Results
Tetanus (last booster)			MMR (Measles, Mumps, Rubella)		
Influenza (yearly)			Varicella (Chicken Pox)		
Pneumovax (pneumonia)			Hepatitis B (3-Shot Series)		
Polio			Tuberculosis skin test		

**SAFETY**

Do you regularly use the following?  
 Seat belts:  Yes  No  
 Helmet (bicycle, motorcycle, sports):  Yes  No  
 Ear/Eye Protection (when needed):  Yes  No  
 Sunscreen (when needed):  Yes  No  
 Are there smoke detectors in your home?  Yes  No  
 If you have guns in your home, are they unloaded and safely locked up?  Yes  No  
 Are you, or have you been, a victim of abuse?  Yes  No  
 Do you have any safety concerns you would like help with? \_\_\_\_\_  Yes  No

**ADVANCE DIRECTIVE**

Name of Healthcare Proxy/Durable Power of Attorney for healthcare: \_\_\_\_\_  
 If you have prepared an Advance Directive (Living Will, Health Care Proxy) please provide us with a copy. If you would like more information, please indicate \_\_\_\_\_

**OB GYN HISTORY- WOMEN ONLY**

Age period began: _____ How often: _____ (days) Number of days your period lasts: _____ Last period date: _____ If your period has stopped what year: _____ Number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____ Number of elective abortions: _____ Type of birth control now used: _____ Did your mother take DES or hormones while pregnant with you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Have you ever been treated for venereal disease/sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had, or currently undergoing, hormonal replacement therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had an abnormal pap? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a colposcopy? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you have any problems or concerns with any of the following?</b> Heavy Flow? <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding between periods? <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding or spotting after intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No Recurrent vaginal discharge or itch? <input type="checkbox"/> Yes <input type="checkbox"/> No Infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No Menopausal Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Premenstrual symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No Sexual function? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you recently (past 5 yrs) had multiple sexual partners? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**HISTORY- MEN ONLY**

Do you perform testicular self-examination? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you recently (past 5 yrs) had multiple sexual partners? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been treated for venereal disease/sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a vasectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you have any problems or concerns with any of the following?</b> Infertility? <input type="checkbox"/> Yes <input type="checkbox"/> No Scrotum or testicles? <input type="checkbox"/> Yes <input type="checkbox"/> No Decrease in stream? <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate? <input type="checkbox"/> Yes <input type="checkbox"/> No Impotence/sexual function? <input type="checkbox"/> Yes <input type="checkbox"/> No Nighttime urination? <input type="checkbox"/> Yes <input type="checkbox"/> No Change in pattern of urination? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**GENERAL HEALTH MAINTENANCE**

Have you undergone?	Date of last	Results	Would you like to discuss?
Physical Exam			
Pap Smear			
Mammogram			
Colonoscopy			
Other test for colon cancer			
Eye Exam			
Hearing Exam			
Dental Exam			
Cholesterol Screening			
Prostate cancer blood test(PSA)			
Bone mineral density test			
Testing for HIV/AIDS/Hep C			



**Evergreen**

Family Health

Is there some other question you wish answered today if there is time? \_\_\_\_\_

Do you need medication refills today? ..... YES NO

Are there any forms you request to be completed today? ..... YES NO

Please indicate if you are having any of the following symptoms:

<b>Constitutional</b>	Old	New
Feeling tired		
Fever / Chills		
Recent weight change		
<b>Eyes</b>	Old	New
Visual changes		
Red eyes		
<b>Ear, Nose, Throat, Mouth</b>	Old	New
Ear pain		
Nasal congestion/Post-nasal drip		
Sore throat		
Sores in mouth		
<b>Cardiovascular</b>	Old	New
Chest painful or tight		
Palpitations / racing heart		
Swelling in feet or ankles		
<b>Respiratory</b>	Old	New
Coughing		
Wheezing		
Shortness of breath		
<b>GI</b>	Old	New
Decreased appetite		
Abdominal pain		
Nausea or vomiting		
Diarrhea		
Constipation		
Heartburn		
Blood in stool		
<b>Urinary</b>	Old	New
Pain during urination		
Frequency of urination		
Blood in urine		

<b>Musculoskeletal</b>	Old	New
Neck pain		
Back pain		
Joint pain		
<b>Skin</b>	Old	New
Skin rash		
Changing mole		
<b>Neurologic</b>	Old	New
Headache		
Dizziness		
Numbness		
Decrease in strength		
<b>Psychiatric</b>	Old	New
Sleep disturbances		
Depression		
Anxiety		
<b>Endocrine</b>	Old	New
Excessive sweating		
Sweating heavily at night		
Excessive thirst		
Feeling hot or cold		
<b>Hem/Lymph</b>	Old	New
Easy bruising		
Swelling		
<b>Allergies</b>	Old	New
Food allergies		
Seasonal allergies		
<b>Gynecological (women only)</b>	Old	New
Irregular vaginal bleeding		
Vaginal discharge		
Vaginal pain, itching or burning		
New/changing breast lump		