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| --- |
| A picture containing table  Description automatically generated |
| Full Name:  |  | Phone #  |  |
| Height:  |  | Weight:  |  | Birth Date:  |  | Age: |  |
| Reason for Today’s Visit:  |  |
| Allergies: |  |
| Referring Physician: |  | Preferred Pharmacy: |  |
| **Previous Surgeries or Hospitalizations** | **Medications** |
| **Surgery/Hospitalization** | **Date** | **Medication** | **Dose** | **Frequency** |
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| **Past Medical History (Check or mark with an “x” if you have/had the following):** |
|  | Heart Disease |  | Asthma |  | Sleep Apnea |  | Diabetes |
|  | High Blood Pressure |  | COPD |  | Kidney Disease |  | Cancer |
|  | Mitral Valve Prolapse |  | Tuberculosis |  | Thyroid Disease |  | Depression/Anxiety |
|  | Stroke/TIA |  | AIDS or HIV |  | Arthritis |  | Anemia |
|  | Blood Clots |  | Hepatitis |  | Acid Reflux/Heartburn |  | Other (Notes Below) |
| **Review of Systems (Check or mark with an “x” if you have/had the following):** |
|  | Weight Gain/Loss |  | Swollen Feet/Ankles |  | Anesthesia Problems |  | Rapid Heartbeat |
|  | Dry Eyes |  | Joint or Muscle Pain |  | Skin Rash |  | Seizures |
|  | Chronic Cough |  | Swollen Lymph Nodes |  | Easy Bleeding |  | Radiation Therapy |
|  | Chest Pain |  | Cold Sore/Fever Blister |  | Easy Bruising |  | Chemotherapy |
| **Family History (Check or mark with an “x” if you or a family member have/had the following):** |
|  | Breast Cancer |  | Diabetes |  | Heart Disease |  | Depression |
|  | Melanoma |  | Kidney Disease |  | High Blood Pressure |  | Anxiety |
|  | Other Cancer |  | Malignant Hyperthermia |  | Stroke/TIA |  |  |
| **Social History:** |
| Do you smoke or use tobacco products?  |  | Do you drink alcohol?  |  |
|  If yes, type and amount per day? |  |  If yes, frequency?  |  |
|  | Do you use “street drugs”?  |  |
| Do you vape? |  |  Description:  |  |
| **Other (please list any other health issue you may be having that is not listed above):** |
|  |
| **Women Only:** |
| Date of Last Mammogram? |  | Bra Size? (if appointment is breast related) |  |
|  Signature: |  | Date: |  |