Patient Name: _____ **Date:** _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs; please continue additional medications on the other side of this page ☐ take no regular medications.

Medication	Dose	Times per day

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS: ☐ **I** am not allergic to any medications.

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:

Do you have any of the following problems?

____ Acid reflux (heartburn)
____ Alcoholism / other addiction
____ Allergies (environmental)
____ Anxiety
____ Asthma
____ Atrial fibrillation
____ Cancer (specify type _____)
____ Coagulation (bleeding or clotting) problem
____ Cholesterol problem
____ Chronic low back pain
____ Depression

____ Diabetes mellitus
____ Erectile dysfunction
____ Heart disease (specify type_____)
____ Hypertension (high blood pressure)
____ Irritable bowel syndrome
____ Migraines
____ Osteopenia or Osteoporosis
____ Prostate problem
____ Thyroid problem
____ Other problems (list below):
____ _____

Patient Name: _____

Have you ever had any of the following problems? If so, please provide approximate year:

Cancer of _____ _____ Heart attack? _____ Blood transfusion? _____
please specify

Stroke (CVA) _____ Seizure? _____

SURGICAL HISTORY (Please list all prior operations and dates)**:** I
□have had no prior surgery.

Operation	Date

Operation	Date

FAMILY HISTORY:

Please indicate with a check (□**)** family members who have had any of the following conditions:

□I do not know my family history.

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism							
Anemia							
Anesthesia problem							
Arthritis							
Asthma							
Birth Defects							
Bleeding problem							
Cancer, Breast							
Cancer, Colon							
Cancer, Melanoma							
Cancer, other skin							
Cancer, Ovary							
Cancer, Prostate							
Cancer (not noted)							
Colon Polyps							
Depression							
Diabetes, Type 1 (child)							
Diabetes, Type 2 (adult)							
Eczema							
Epilepsy (Seizures)							

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Genetic diseases							
Glaucoma							
Hay fever (Allergies)							
Hearing problems							
Heart Attack (CAD)							
High Blood Pressure							
High cholesterol							
Kidney diseases							
Lupus (SLE)							
Mental retardation							
Migraine headaches							
Mitral Valve Prolapse							
Osteoarthritis							
Osteoporosis							
Rheumatoid Arthritis							
Stroke (CVA)							
Thyroid disorders							
Tuberculosis							
Other:							

Patient Name: _____

SOCIAL HISTORY

SUBSTANCES:

Tobacco Use

Please check one:

□ I have never smoked.

□ I have smoked, but rarely.

When was the last time? _____

_I have quit smoking: Quit date_____

_I currently smoke ___pack(s)/day, # of yrs___

Other Tobacco: _Pipe _Cigar _Snuff _Chew

Are you interested in quitting? _No _Yes

Alcohol Use

Do you drink alcohol? Never Occasionally Regularly

Average# drinks/week: ___5 oz glasses wine;

___12 oz cans beer; ___1.5 oz shots hard liquor

Is alcohol use a concern for you or others? _ No _Yes

Drug Use

Do you use any recreational drugs? _ No _Yes

Have you ever used needles? _ No _Yes

SEXUALITY:

Sexual Activity

Current sex partner(s) is/are: male female

Contraception and Protection

Birth Control method:_____

If sexually active, do you practice safe sex? N/A Yes No

Have you ever had any sexually transmitted diseases(STDs)?

_No _Yes

If yes, please include: _____date_____

Are you interested in being screened for sexually transmitted diseases? _ No _ Yes

Other concerns?_____

_____

SOCIOECONOMICS:

(check only one)

Asian Black, Non-Hispanic Hispanic

Native American Native Hawaiian & Other Pacific Islander

White, Non-Hispanic Other Decline

Marital status: _Single _Married _Sep _Div _Widow

_Co-habiting _Engaged _Other _____

Female patients only:

Date of last menstrual cycle: _____

Number of children: _____ Number of live births:_____

Vaginal: _____ Cesarean: _____

Number of children: ____

Who lives at home with you? _____

Occupation:_____

EMOTIONS:

Over the past two weeks, how often have you been bothered by any of the following problems?

Please insert appropriate number for each question, using the following scale:

0 = Not at all

1 = Several Days

2 = More than half the days

3 = Nearly every day

Little interest or pleasure in doing things? _____

Feeling down, depressed or hopeless? ____

PREFERRED PHARMACY: _____

Patient Name: _____ **Date:** _____

IMMUNIZATIONS:

Please list your most recent immunizations. You do NOT need to include any immunizations given at Atrius Health. Please include your best estimate of the month and year of each immunization:

Hepatitis A ____ Measles ____ Mumps____ Rubella____ Pneumovax (Pneumonia)____

Hepatitis B ____ MMR____ Meningitis____ Shingles____

HPV ___ Varicella (chicken pox) shot ____ Other _____

Tetanus (Td) ____ TdaP____

REVIEW OF SYMPTOMS: Please check (□) any <u>current</u> problems you have on the list below.

Breasts

___Breast pain/lump/discharge

Constitutional

___Fevers/chills/sweats

___Unexplained weight loss/gain?

___Fatigue/weakness

Eyes

___Change in vision

***E* ars/Nose/Throat/Mouth**

___Difficult hearing

___Ringing in ears

___Problems with teeth/gums

___Hay fever/allergies

Respiratory

___Cough/wheeze

___Difficulty breathing

Cardiovascular

___Chest pain/discomfort

___Leg pain with exercise

___Palpitations

Gastrointestinal

___Abdominal pain

___Heartburn

___Bloody/black bowel movement

___Nausea/vomiting/diarrhea

___Constipation

___Change in bowel habits

Genitourinary

___Nighttime urination

___Difficulty starting urination

___Leaking urine

___Painful urination

___Blood in urine

___Discharge from penis

___Sexual function problems

Musculoskeletal

___Muscle/joint pain or swelling

Neurological

___Headaches

___Dizziness/light-headedness

___Numbness

___Memory loss

___Loss of coordination

Psychiatric

___Anxiety/stress

___Problems with sleep

___Depression

Skin

___Rash or mole change

___Itching

Blood/Lymphatic

___Unexplained lumps

___Easy bruising/bleeding

Endocrine

___Excessive thirst or urination

Other (please specify) _____

_____

_____

☐ I have none of the above problems.

Revised: June 2011; AB/IM Design