

MRN # \_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Provider you are seeing today: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please state your problem in your own words as to why you are here today:

Did a physician request that you see one of our providers today? ☐ Yes ☐ No If yes, name of physician: \_\_\_\_\_

<input type="checkbox"/> Acute Myocardial Infarction (Heart Attack)	<input type="checkbox"/> Chronic Liver Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Anemia (Low Blood Count)	<input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease)	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Mitral Valve Disorder	<input type="checkbox"/> Stroke Syndrome
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Murmurs	<input type="checkbox"/> Thromboembolic Disease (Blood Clot Disorder)
<input type="checkbox"/> Autoimmune Disorder (Lupus/Scleroderma/RA)	<input type="checkbox"/> Gastric/duodenal Ulcer	<input type="checkbox"/> Obesity	<input type="checkbox"/> Thrombophlebitis
<input type="checkbox"/> Blood Transfusion Complications	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Cancer - list type(s): _____	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Transient Ischemic Attack (Mini Stroke)
	<input type="checkbox"/> Hepatic (Liver) Disorder	<input type="checkbox"/> Peripheral Vascular Disease (Poor Circulation)	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other (specify): _____
	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Pulmonary Disease (Lung Disease)	
<input type="checkbox"/> Chest Pain (Angina)	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Recent Methicillin-resistant Staph aureus (MRSA)	
	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Rheumatic Fever	
	<input type="checkbox"/> Irritable Bowel Syndrome		

Surgery: ☐ No Surgical History

Surgery	Date	Surgery	Date

Family History (check all that apply): ☐ No Family Medical History

	Family Member*		Family Member*
<input type="checkbox"/> Anemia (Low Blood Count)		<input type="checkbox"/> Hypercholesterolemia	
<input type="checkbox"/> Cancer - list type(s): _____		<input type="checkbox"/> Hypertension	
		<input type="checkbox"/> Osteoporosis	
		<input type="checkbox"/> Pulmonary Disease	
<input type="checkbox"/> COPD		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Stroke Syndrome	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Thromboembolic Disease	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Unattainable-Patient Adopted	
<input type="checkbox"/> Hepatic (Liver) Disorder		<input type="checkbox"/> Other: _____	
Family Health Status of Father - Deceased		Age: _____	Cause: _____
Family Health Status of Mother - Deceased		Age: _____	Cause: _____

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Social History:**Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced ☐ Life Partner

(check all that apply)

☐ Alcohol Use: Weekly: \_\_\_\_\_☐ Drug Use (Recreational): Explain: \_\_\_\_\_☐ Use Intravenous Drugs: Explain: \_\_\_\_\_☐ Previous History of Smoking: Date Quit: \_\_\_\_\_ Packs Per Day \_\_\_\_\_ Years of Smoking: \_\_\_\_\_

Attempts to Quit: \_\_\_\_\_ Methods Used to Quit: \_\_\_\_\_

☐ No History of Smoking ☐ Wishing to Stop Smoking☐ Smoking/Nicotine Substances: ☐ Cigarettes Packs/times Per Day: \_\_\_\_\_ Years \_\_\_\_\_☐ Cigars ☐ Chewing ☐ Tobacco ☐ Pipe☐ Current Diet: Explain: \_\_\_\_\_☐ Occupation: List All: \_\_\_\_\_☐ Travel: If recently out of the country, where? \_\_\_\_\_Do you have an advanced directive? ☐ Yes ☐ No**Allergies:** ☐ No Known Allergies

Allergy	Reaction	Allergy	Reaction

**Medications** (Include vitamins, herbal supplements and over the counter medications): ☐ No Current Medications

Medications	Dosage	Frequency	Reason for Taking

Have you participated in any clinical trials or used experimental drugs? ☐ Yes ☐ No Explain: \_\_\_\_\_Are you pregnant? ☐ Yes ☐ No Last Menstrual Period Date: \_\_\_\_\_

Is there anything else about your medical history that we should know?

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

I certify that I have reviewed the above information with the patient.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_