

## PATIENT DEMOGRAPHICS

Full Name:

Date of Birth (YYYY-MM-DD):

Sex/Gender:

Address:

Phone Number:

Email:

## EMERGENCY CONTACT & PCP

EC Name:

EC Phone:

Primary Care Physician:

## VISIT DETAILS

Reason for visit:

Duration of concern:

Symptoms description:

## MEDICAL HISTORY & MEDICATIONS

Pre-existing conditions:

Surgeries / Hospitalizations:

Serious injuries or accidents:

Current prescriptions:

Supplements:

Alternative medicine:

Medication allergies:

Food allergies:

Environmental allergies:

Infectious diseases:

## FAMILY HISTORY

Heart disease

Diabetes

High blood pressure

Stroke

Mental health conditions

Cancer (type):

Other:

## RECENT EXAMS & VACCINATIONS

Last physical exam:

Last blood test:

Last major vaccination:

## LIFESTYLE

Smoke tobacco

Tobacco quantity/day:

Tobacco duration (yrs):

Drink alcohol

Drinks per week:

Use recreational drugs

Drug type & frequency:

Exercise habits:

Diet description:

## WOMEN'S HEALTH

Last menstrual period:

Pregnant or possibly pregnant

Last mammogram / Pap smear:

## REVIEW OF SYSTEMS

Fever or chills

Fatigue or weakness

Weight loss or gain

Chest pain

Shortness of breath

Cough

Headache

Vision changes

Hearing changes

Abdominal pain

Nausea or vomiting

Joint pain

Skin rashes

Dizziness or fainting

Mood changes

Other symptoms:

## ADDITIONAL COMMENTS & RED FLAGS

Additional comments:

Red flags for MD review:

## SIGNATURE

Signature:

Signature Date (YYYY-MM-DD):