

Medications (please complete if you are a new patient to our practice)

Medications and Dosage	Reason and comments
_____	_____
_____	_____
_____	_____
_____	_____

Past Medical and Surgical History (please complete if you are a new patient to our practice)

List all medical history and past surgeries	Date (year) and comments
_____	_____
_____	_____
_____	_____
_____	_____

Physicians Involved in Your Care

List all past and current physicians and their specialties (other than PCP)	Telephone and email
_____	_____
_____	_____
_____	_____
_____	_____

***** For Female Patients Only*****

Mammogram (dates & results) _____

Pap smear (dates & results) _____

Number of pregnancies & births _____

Did you breast-feed? (Yes or No) _____

Last menstrual cycle _____

Reviewed by Dr. _____

Symptoms

Have you had any of the following symptoms in the past 60 days?
(Please circle symptoms you have and describe)

Constitutional (fever, weight loss, fatigue, loss of appetite) _____

Eyes (double vision, blurring, glasses) _____

ENT, Mouth (deafness, sinusitis, dizziness) _____

Heart (chest pain, murmur, irregular beats) _____

Circulation (high blood pressure) _____

Respiratory (asthma, shortness of breath, chronic cough, spitting up blood) _____

GI (appetite, diarrhea, constipation, nausea/vomiting) _____

Urinary (problem urinating, burning or painful, blood in urine) _____

GYN (menstrual problems, pregnancies) _____

Musculoskeletal (arthritis, stiffness) _____

Skin (acne, rash or itching, change in skin color, change in nail color) _____

Breast (lump, pain, discharge) _____

Neurological (seizures, stroke, headaches, weakness, balance) _____

Psychiatric (depression, mood liability) _____

Endocrine (thyroid problems) _____

Hematologic (bleeding tendency, anemia) _____

Lymphatic (enlarged lymph nodes) _____

Infectious disease (hepatitis, TB, HIV/AIDS) _____

Reviewed by Dr. _____