PLEASE COMPLETE DURING YOUR WAIT TO SEE THE PROVIDER TODAY

PATIENT NAME: ____ **DOB:**____________

CALL BACK PHONE#:_________________ **PARENT/GUARDIAN NAME:** ___________________________

NAME OF INSURANCE COMPANY ____

PRIMARY CARE PHYSICIAN: ___________________________________

I would like my visit notes to be sent to the physician listed above. ☐ *Yes* ☐ *No*

REASON FOR TODAY'S VISIT: ____

PHARMACY OF CHOICE: ____

CURRENT MEDICATIONS: **(If you have a list we will make a copy and attach it to this form)**

____

____

ALLERGIES: List any allergies to **medications or other materials** *(e.g. latex)*. What was the reaction?

____

____

CURRENT SYMPTOMS: please read the following list of symptoms and mark all of those that you are experiencing ***today*** or with ***current illness***.

CONSTITUTIONAL
- Change in Appetite
- Chills
- Fatigue
- Fever
- Sweats
- Weight Loss

CARDIOVASCULAR
- Chest Pain/Pressure
- Fainting
- Fluttering/Palpitations
- Leg Swelling

NEUROLOGICAL
- Headache
- Light Headedness
- Loss of Consciousness
- Numbness/Tingling
- Poor balance
- Weakness

PSYCHIATRIC
- Anxiety/Nerves
- Depression
- Sleep difficulties

LYMPH
- Easy Bleeding
- Frequent Infections
- Nodes/Glands

EYES
- Blurred Vision
- Contact Lenses
- Double Vision
- Eye Discharge
- Eye Pain
- Eye Redness
- Eye Swelling
- Wear Eyeglasses

ENT and Mouth
- Difficulty Swallowing
- Dizziness
- Ear Pain
- Hoarseness
- Mouth Pain
- Nasal Congestion
- Nasal Discharge
- Sore Throat

RESPIRATORY
- Congestion
- Cough
- Shortness of Breath
- Snoring
- Wheeze

GI
- Abdominal Pain
- Blood in Stool
- Constipation
- Diarrhea
- Nausea
- Rectal/Perirectal Complaints
- Urinary/Bowel Changes
- Vomiting

GU
- Blood in Urine
- Discharge
- Frequent Urination
- Menstrual Complaints
- Nighttime Urination
- Painful Urination
- Sexual Difficulties

MUSCULAR
- Back Pain
- Joint/Muscle Pain
- Swelling

SKIN
- Bruising
- Itching
- Laceration
- Rash
- Redness
- Skin sore

Endocrine
- Abnormal Blood Sugar
- Cold Intolerance
- Excessive Hunger/Thirst
- Hair Loss
- Heat Intolerance

Allergy/Immune.
- Itchy Eyes
- Lip/Tongue/Throat Swelling
- Post-Nasal Drip
- Sneezing

PLEASE CONTINUE TO BACK SECTION

MEDICAL HISTORY List all past surgeries and dates:

____

____

SOCIAL HISTORY

Do you currently or have you in past used products such as **cigarettes, cigars, pipes, or smokeless tobac**co?

Yes Which kind? ______________________ How much/often? ______________________

No Quit Which kind? ______________________ When did you quit? ______________________

Never

Do you **consume alcohol**?

Yes How much/often? ____

No

Do you currently or have you in the past used illegal drugs such as **marijuana, cocaine, methamphetamines**?

Yes Which kind? ______________________ How much/often? ______________________

No Quit Which kind? ______________________ When did you quit? ______________________

Never

IMMUNIZATIONS

Have you received any of these vaccines?

Flu Vaccine When? ______________

Tetanus When? ______________

TDAP (pertussis) When? ______________

Are you current on your **childhood immunizations**?

Yes

No

FAMILY HISTORY

Do ***you*** or a ***family member (***father, mother, or sibling) have a history of any of the following?

Cardiovascular (Heart) Whom? ____________________________

High Cholesterol Whom? ____________________________

Cancer/Leukemia Whom? ____________________________

High Blood Pressure Whom? ____________________________

Brain Aneurism Whom? ____________________________

Diabetes Whom? ____________________________

Alzheimer’s Whom? ____________________________

Psychiatric (Depression, Bipolar, etc.) Whom? ____________________________