CHIEF COMPLAINT:
(What problem brings you to the doctor today; e.g., headache, back pain, leg pain?)

HISTORY OF THE PRESENT ILLNESS/CHIEF COMPLAINT:
(Describe the signs/symptoms that you have, when they started, and how they have changed.)
Location: (where is the problem?)
Quality: (dull, throbbing, sharp)
Severity: (mild, moderate, severe)
Context: (how did this occur?)
Timing: (daily, with activity, at night)
Duration: (when did it first occur?)
Associated Signs and Symptoms:
Modifying Factors: (what makes it better or worse?)

PRESENT PRESCRIPTION MEDICATIONS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
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PAST MEDICAL HISTORY:
Do you now have or have you ever had:

- Diabetes  No [ ] Yes [ ]
- High Blood Pressure  No [ ] Yes [ ]
- Cancer  No [ ] Yes [ ]
- Stroke  No [ ] Yes [ ]
- Heart Disease  No [ ] Yes [ ]
- Arthritis / Gout  No [ ] Yes [ ]
- Seizures  No [ ] Yes [ ]
- Bleeding Tendency  No [ ] Yes [ ]
- Chronic Infections  No [ ] Yes [ ]
- Connective Tissue Disease  No [ ] Yes [ ]
- High Cholesterol  No [ ] Yes [ ]
- Thyroid Disease  No [ ] Yes [ ]
- Asthma  No [ ] Yes [ ]
- GERD / Acid Reflux  No [ ] Yes [ ]
- Kidney Stones  No [ ] Yes [ ]
- Sleep Apnea  No [ ] Yes [ ]
- Depression  No [ ] Yes [ ]
- MRSA  No [ ] Yes [ ]
- Other:

PRESENT OVER-THE-COUNTER MEDICATIONS:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
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ALLERGIES TO MEDICATIONS:

REACTION:
(Rash, Hives, Etc.)
PATIENT NAME: ____________________________     DATE ___________   ACCT #: _____________

HOSPITALIZATIONS / SURGERIES/ SERIOUS INJURIES:   DATE:

FAMILY MEDICAL HISTORY:

<table>
<thead>
<tr>
<th>Age</th>
<th>Diseases</th>
<th>Age at Death</th>
<th>Cause of Death?</th>
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</thead>
<tbody>
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PATIENT SOCIAL HISTORY:

<table>
<thead>
<tr>
<th>Tobacco Use:</th>
<th>Current Smoker / #Packs/Day</th>
<th>Former Smoker / Year Quit</th>
<th>Never Smoked</th>
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<tr>
<th>Alcohol Use:</th>
<th>Yes</th>
<th>No</th>
<th>If yes, how many drinks per month?</th>
<th>per week?</th>
<th>per day?</th>
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<tr>
<th>Substance Abuse:</th>
<th>Never</th>
<th>Past / Year Quit</th>
<th>Currently – Type / Frequency</th>
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<tr>
<th>Occupation:</th>
<th>Currently Working</th>
<th>Yes</th>
<th>No</th>
<th>Date Last Worked?</th>
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<tr>
<th>Marital Status:</th>
<th>Single</th>
<th>Married</th>
<th>Widowed</th>
<th>Divorced</th>
<th>Number of Children:</th>
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REVIEW OF SYSTEMS: Do you now have or have you ever had any of the following?

GENERAL HEALTH:

- Prolonged Fever
- Unintentional Weight Change

GENITOURINARY:

- Frequent Urination
- Incontinence of Urine
- Kidney Stones

EYES:

- Eyeglasses / Contacts
- Eye Disease or Injury

MUSCULOSKELETAL:

- Joint Pain
- Muscle Pain / Cramps

EAR, NOSE, MOUTH, THROAT:

- Hearing Loss
- Chronic Sinus Trouble
- Sore Throat

NEUROLOGICAL:

- Frequent Headaches
- Head Injury

CARDIOVASCULAR:

- Chest Pain
- Congestive Heart Failure

PSYCHIATRIC:

- Memory Loss
- Anxiety
- Depression

RESPIRATORY:

- Shortness of Breath
- Chronic Cough

ENDOCRINE:

- Fatigue
- Hair Loss

GASTROINTESTINAL:

- Diarrhea / Constipation
- Acid Reflux / Heartburn
- History of Ulcers

HEMATOLOGIC / LYMPHATIC:

- Anemia
- Easy Bruising

HEALTH MAINTENANCE:

- Have you had any falls in the last year that resulted in injury? ☐ Yes ☐ No
- Have you had two or more falls in the last year? ☐ Yes ☐ No
- Date of last DEXA bone density study? _____ / _____
- Date of last influenza vaccine? _____ / _____
- Date of last pneumonia vaccine? _____ / _____
- Have you traveled outside of the United States in the past 30 days? ☐ Yes ☐ No

Patient Signature                                        Date             Physician Signature                                             Date

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