



Date: _____

Patient: _____

Date of Birth: _____

Allergies (Drug/Medication/Food/Environmental)	Reaction	Severity
<i>Example: Penicillin</i>	<i>Nausea</i>	<i>Moderate</i>

Medications	Dose	Frequency	Prescriber
<i>Example: Metoprolol</i>	<i>25 mg</i>	<i>1 tablet two times daily</i>	<i>Dr. John Smith</i>

Attach additional sheet if necessary.

Other Providers/Specialists <small>(Including previous Specialists)</small>	Specialty
<i>Example: Dr. John Smith</i>	<i>Chiropractor</i>

Attach additional sheet if necessary.

Preferred Local Pharmacy:

Preferred Mail Order Pharmacy, if applicable:

Laboratory – In the last 12 months, where have you received laboratory services? Please list Lab name(s).



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Advanced Care Planning – Please provide a copy.			
<input type="checkbox"/> Living Will	<input type="checkbox"/> POLST	<input type="checkbox"/> Advanced Directive	<input type="checkbox"/> I would like more information about Advanced Care Planning

History of Vaccines and Screenings	Yes	No	Date	Provider or Location
Have you received a flu shot this season?				
Have you ever received a vaccine for pneumonia?				
If you are over the age of 50:	Yes	No	Date	Provider or Location
Have you had a Fecal test (stool card) in the last year?				
Have you had a colonoscopy in the last 10 years?				
If you are Female:	Yes	No	Date	Provider or Location
Have you had a mammogram in the last 5 years?				
If you are Diabetic:	Yes	No	Date	Provider or Location
Have you had a diabetic foot exam in the last year?				
Have you had a diabetic eye exam in the last year?				

Past Medical History – Check all that apply. <input type="checkbox"/> NONE			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Benign Prostatic Enlargement	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> GERD	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Angina	<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> COPD	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Crohn's Disease/Colitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Gait/Balance Problems	<input type="checkbox"/> Muscle Weakness/ Disorder	<input type="checkbox"/> Restless Leg Syndrome
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Irritable Bowel Disease	<input type="checkbox"/> Myasthenia Gravis	<input type="checkbox"/> Tremors
<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Vertigo/ Dizziness
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lumbar Radiculopathy	<input type="checkbox"/> Parkinson Disease	<input type="checkbox"/> Vision Loss
<input type="checkbox"/> Facial pain	<input type="checkbox"/> Mental Health Illness: _____	<input type="checkbox"/> Polyneuropathy	<input type="checkbox"/> Other: _____

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Past Surgical History – Check/circle all that apply. <input type="checkbox"/> NONE					
Surgery	Year	Surgery	Year	Surgery	Year
<input type="checkbox"/> Angioplasty		<input type="checkbox"/> Cardiac Pacemaker or Defibrillator: _____		<input type="checkbox"/> Mastectomy	
<input type="checkbox"/> Appendectomy (Appendix Removal)		<input type="checkbox"/> Colectomy		<input type="checkbox"/> Open Reduction Internal Fixation (ORIF): _____	
<input type="checkbox"/> Arthroscopy Area: _____		<input type="checkbox"/> Colostomy		<input type="checkbox"/> Prostate Surgery	
<input type="checkbox"/> Neck or Back Surgery		<input type="checkbox"/> Dilation & Curettage (D&C)		<input type="checkbox"/> Thyroidectomy (Thyroid Removal)	
<input type="checkbox"/> Blood Transfusion		<input type="checkbox"/> Gastric Bypass		<input type="checkbox"/> Tonsillectomy (Tonsil Removal)	
<input type="checkbox"/> Coronary Artery Bypass Grafting (CABG)		<input type="checkbox"/> Heart Surgery or Valve Replacement		<input type="checkbox"/> Uterine Surgery	
<input type="checkbox"/> Knee Replacement LEFT RIGHT		<input type="checkbox"/> Hip Replacement LEFT RIGHT		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Cataract Extraction LEFT RIGHT		<input type="checkbox"/> Hysterectomy		<input type="checkbox"/> Cholecystectomy (Gallbladder Removal)	
<input type="checkbox"/> Carpal Tunnel Release LEFT RIGHT		<input type="checkbox"/> LASIK LEFT RIGHT		<input type="checkbox"/> Other: _____	

Family History – Check all that apply.						
	Mother <input type="checkbox"/> None	Father <input type="checkbox"/> None	Sister <input type="checkbox"/> None	Brother <input type="checkbox"/> None	Daughter <input type="checkbox"/> None	Son <input type="checkbox"/> None
Alzheimer's Disease						
Arthritis						
Asthma						
Cancer: _____						
Cardiovascular Disease						
Depression						
Diabetes						
High Cholesterol						
High Blood Pressure						
Mental Health Illness: _____						
Movement Disorders						
Nerve or Muscle Disease						
Osteoporosis						
Seizure Disorder						
Stroke						
Substance Use: _____						
Thyroid Disorder						
Tremors						
Other: _____						



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Residence – Patient lives with:		
<input type="checkbox"/> Spouse or Domestic Partner	<input type="checkbox"/> Son	<input type="checkbox"/> Daughter
<input type="checkbox"/> Alone	<input type="checkbox"/> Assisted Living Facility:	<input type="checkbox"/> Other:

Exercise	
Type: _____ _____ _____	Frequency <input type="checkbox"/> Occasional <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> 4-5 Times a week <input type="checkbox"/> Daily

Communication Needs	Yes	No
Do you have difficulty with hearing?		
Do you have difficulty with your vision?		
Have you had difficulty remembering things that have happened recently?		

My Personal and Lifestyle Goals – Check all that apply.	
<input type="checkbox"/> Eat a healthier diet	<input type="checkbox"/> Get regular physical activity
<input type="checkbox"/> Achieve/maintain a healthy weight	<input type="checkbox"/> Maintain a cheerful, hopeful outlook on life
<input type="checkbox"/> Get adequate rest daily	<input type="checkbox"/> Other:
I believe I am not meeting my lifestyle goals because: _____ _____	

Substance Use		
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Former substance user

I certify that the information provided is correct to the best of my knowledge.

Signature

Date

Print Guardian Name (if other than patient)

Relationship