To help facilitate your initial appointment, please complete the questions below and bring this document with you to your appointment.

|  |  |  |
| --- | --- | --- |
| Name: | Date: | Date of Birth: |
| Current Medical Conditions |  |
|  |
|  |
|  |
|  |
| Medications |
| Please list all of the medications that you are currently taking. Attach additional pages if needed. |
| Name of medication | Dosage | Number of times daily |
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| --- |
| Are you taking any of the following medications? Please check Yes or No |
| Medication | Yes | No |
| Aspirin |  |  |
| Ibuprofen (Advil®) or naproxen (Aleve®) |  |  |
| Vitamin D |  |  |
| Calcium |  |  |
| Multivitamin |  |  |
| Other vitamin or supplement |  |  |

|  |  |
| --- | --- |
| Name of your previous primary care physician: |  |

Allergies/Intolerance

Please list any medications allergies along with reaction (example: penicillin – rash). Attach additional sheets if necessary.

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| --- |
| 1. |
| 2. |
| 3. |

Do you have a latex allergy? Yes No

Medical History

Please list any medical conditions.

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| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |

Please check any other current/past medical conditions you have not already listed above:

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| --- | --- | --- |
|  Anemia |  Emphysema/COPD |  Liver disease |
|  Anxiety |  Glaucoma |  MRSA (staph) infection |
|  Arthritis  |  Gout |  Osteoporosis/osteopenia |
|  Asthma |  Heart disease |  Sexually transmitted illness |
|  Blood clots |  High blood pressure |  Skin cancer |
|  Depression |  High cholesterol |  Thyroid disease |
|  Diabetes |  Kidney disease |  Tuberculosis |

Please indicate if you have completed any of the following procedures/treatments:

|  |  |  |
| --- | --- | --- |
| Procedure/ Treatment | Yes | Date Completed |
| Flu vaccine |  |  |
| Pneumonia vaccine (Pneumovax®) |  |  |
| Tetanus vaccine |  |  |
| Shingles vaccine (Zostavax) |  |  |
| COVID-19 vaccine  |  |  |
| Colonoscopy |  |  |
| Prostate cancer screening (men) |  |  |
| Mammography (women) |  |  |
| Bone density test (women) |  |  |
| Pap test / pelvic exam (women) |  |  |

Past Surgical History

Please list your surgical history.

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| --- | --- | --- |
| Type of Surgery | Date of Surgery (Year) | Surgeon |
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Obstetrical/Gynecological History

For women, please indicate your obstetrical and gynecological history below.

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| --- | --- | --- | --- | --- | --- |
| History of | Number |  | History of | Yes | No |
| Pregnancies |  |  | HPV |  |  |
| Miscarriages |  |  | Abnormal pap |  |  |
| Abortions |  |  | Date of last menstrual period |  |  |

What is your current form of birth control? Please check all that apply.

None Medication Tubal ligation Vasectomy IUD Condom

Family History

|  |  |  |  |
| --- | --- | --- | --- |
|  | Health History | Living | If deceased, list cause of death |
| Father |  |  |  |  |  |
| Mother |  |  |  |  |  |
| Siblings |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
| Children |  |  |  |  |  |
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Social History

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Married Single Divorced Widowed

Do you exercise? Yes No

 If yes, how many days per week? \_\_\_\_\_\_\_\_\_\_

Are you sexually active? Yes No

 If yes, are your partners? Men Women Both

Have you ever smoked? Yes No

 If yes, what? cigarettes pipe cigars e-cigs/vaping chewing tobacco How many years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you usually drink over 2 cups of caffeinated beverages per day?

 Yes No How many do you drink per day? \_\_\_\_\_\_\_\_\_\_

Do you regularly drink alcohol? Yes No

 If yes, please check the answer(s) that best describe your consumption.

 Liquor 1 oz/day 2 oz/day 4 oz/day 6+ oz/day

 Beer 1 bottle/day 2 bottles/day 3+ bottles/day

 Wine 1 glass/day 2 glasses/day 3+ glasses/day