Please give an accurate answer to the following due to these questions

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

**MR# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***(Office use Only – Do Not Complete) (Office use Only – Do Not Complete)***

**Reason for Visit:**

**Medical History: Do you have or have you had?**

**Yes Yes**

Diabetes Lung Problems

High Blood Pressure Cancer

Heart Problems Gout

Stroke Stomach Problems

Kidney Problem Gallbladder Problems

Skin Disease Hepatitis

Anemia Seasonal Allergies

### *Was your last tetanus vaccine: More than 10 years ago*

*If you are over 65, have you received the pneumonia vaccine? Yes*

### *Do you receive yearly flu shots? Yes*

*Date of last Medical Exam:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Hospitalizations: (Please include illnesses, injuries and surgeries)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Reason Date Location

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Reason Date Location

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Reason Date Location

### Family History:

**Cause of Death**

Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has anyone in your family had?**

Cancer Yes

Heart disease Yes

##### Liver disease Yes

##### Lung disease Yes

Kidney disease Yes

##### Intestinal or colon problems Yes

Diabetes Yes

Hypertension Yes

**Social History:**

Do you drink alcohol? Yes

##### Do you use tobacco? Yes

Do you use cocaine, marijuana, heroin Yes

**Have you noted any recent changes with:** Weight gain or weight loss Yes

(Constitutional) Problems with sleeping Yes

Fever Yes

**Do you have any problems with**: Headaches Yes

(Head and Neck) Dizziness or lightheadedness Yes

Sore throat Yes

Swallowing Yes

**Do you have any problems with**: Blurred or double vision Yes

(Eyes) Cataracts Yes

Do you wear glasses or contact Glaucoma Yes

Lenses? Yes Eye infections Yes

**Do you have any problems with**: Changes in hearing Yes

(Ears, Nose and Throat) Buzzing or ringing in the ears Yes

Earaches or ear infections Yes

Motion sickness Yes

Do you wear dentures? Frequent sinus problems or colds Yes

Yes Nose bleeds Yes

Mouth pain or difficulty chewing Yes

Bleeding gums or mouth sores Yes

Taste change Yes

Hoarse voice or difficulty talking Yes

**Do you have any problems with**: Asthma Yes

(Respiratory System) Tuberculosis Yes

Bronchitis or pneumonia Yes

##### On how many pillows do you sleep? Difficult or painful breathing Yes

\_\_\_\_\_\_ Cough Yes

Night sweats Yes

###### Can you climb a flight of steps without resting? Yes

###### Have you had a cough that has lasted for more than 2 weeks? Yes

Have you had a skin test for TB? Yes

What was the result? Positive \_\_\_\_ Negative \_\_\_\_

## Do you have problems with: Chest pain Yes

## (Cardiovascular System) Palpations or irregular heartbeat Yes

Heart failure Yes

Ankle swelling Yes

High cholesterol or triglycerides Yes

## Do you have problems with: Nausea or vomiting Yes

## (Gastrointestinal System) Vomiting blood Yes

##### Constipation Yes

##### Black stools or bloody stools Yes

##### Blood in stools Yes

##### Diarrhea Yes

##### Do you have problems with: Bone or joint pain Yes

(Musculoskeletal System) Muscle pain or weakness Yes

**Do you have problems with:** Weakness in the arms or legs Yes (Neurological System) Paralysis or numbness Yes

Shaking or tremors Yes

Loss of consciousness or passing out Yes

Seizures or fits Yes

**Do you have problems with:** Itching or burning of the skin Yes

(Skin) Sores or rashes Yes

##### Do you have problems with: Lack of concentration or memory Yes

(Mood) Loss of temper Yes

Excessive worrying or crying Yes

## Do you have problems with:

(Genitourinary System) Kidney stones Yes

## Venereal disease (VD) Yes

## Nighttime urination? Yes

## Any problem with erection Yes

Have you ever been pregnant? Yes

Did you have any problems with pregnancy? Yes

Have you gone through menopause? Yes

Have you had any bleeding or discharge from the vagina? Yes

Have you ever had any operations or infections of the uterus, fallopian tubes or ovaries? Yes

Do you have any lumps, swelling or tenderness of the breasts? Yes

Date of last PAP smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please do not write below this line

##### For Physician Use Only

All other systems are negative

Review of systems unobtainable

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History obtained from (other source) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No other source available

(Problems with positive or pertinent negative findings must be individually documented)

(**Problem pertinent = 1 system, Extended = 2 to 9 systems; Complete = 10+ systems)**

**Attending Physician’s Note: (CC/HPI)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Attending Physician’s Signature Date

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_