Patient Name: ______________________________ PCP: ____________________________

Medications: List each drug, its amount, and how often you take them.
1. 
2. 
3. 
4. 
5. 

Medication Allergies: Yes / No
If yes, list medication and the reaction you had with them

Medical Illnesses or Conditions:
Anxiety Disorder | Arthritis | Asthma | COPD | Cancer | Coronary Artery Disease | Depression | Diabetes | Diverticulitis | Fibromyalgia | GERD/Reflux | Gout | Heart Disease | High Cholesterol | HIV | Hypertension | Hyperthyroidism | Hypothyroidism | Kidney Disease | Kidney Stones | Liver Disease | Osteoporosis | Pulmonary Embolism | Stroke | Tuberculosis |
Other ____________________________

Hospitalizations & Operations: List and indicate approximate year.

Social History
Do you smoke? Yes/No When did you stop? _______
Cigarettes | Cigars | Pipe |Chewing tobacco | Snuff
How much do/did you use per day? _______ Number of years? ___ Since age ______
Have you been exposed to secondhand smoke at home or work?

Do you drink alcoholic beverages regularly?
Hard liquor 1-3 oz. per day | Over 3 oz. per day
Beer 1 bottle per day | 2 bottles per day | 3 or more
Wine 1 glass per day | 2 glasses per day | 3 or more
Caffeine intake – Yes/ No | 3 or more cups

Did you, or do you, use marijuana? Yes/No
Have you used cocaine, heroin or other __________________

Relationship Status:
Married | Single | Domestic Partner | Civil Union Relationship | Separated | Divorced | Widowed
Living Situation:
Live alone | Live with a spouse or partner | Live with roommates | Live with parents or other family members | Other | Number of dependents at home __________

Religion ________________

Education: Grade School | High School | College | Other

Gender Identity:
Male | Female | Transgender F2M | Transgender M2F | Other

Sexual Orientation:
Heterosexual | Bisexual | Gay | Lesbian | Other | Not sure

Main language: English | Spanish | Creole | Other
Need a translator? _________

Do you exercise? Regularly | Occasionally | Rarely

Do you use any community services? (Transportation, Meals on Wheels etc.)

Diet: Regular | Vegetarian | Vegan | Gluten Free | Lactose Free

Are you currently being abused physically, sexually, or emotionally?

**Occupation/Work History & Environmental Exposure**
What is your current occupation?
Did you previously have a different occupation?
Were you ever exposed to the following? Please check or circle all that apply.
Asbestos | Chronic Fumes | Chronic Dust | Radiation | Toxic Chemicals

**Family Health History**

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<thead>
<tr>
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<th>Alive</th>
<th>Dead</th>
<th>Age</th>
<th>Cause of Death</th>
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<tbody>
<tr>
<td>Mother</td>
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<tr>
<td>Father</td>
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<td>Daughter</td>
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<td>Brother</td>
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</tr>
</tbody>
</table>

**Gastroenterology**
Lost appetite | Recent weight change | Swallowing problems | Solids stick | Choking | Food comes out your nose | Heartburn | Ulcer | Nausea | Vomiting | Vomit blood | Diarrhea | Upset stomach (food related) | Constipation | Black bowel movements | Bloody bowel movements | yellow or jaundiced | Cirrhosis | Indigestion | Cramps | Bloating | Fullness | Past Endoscopy | Past Colonoscopy |
Findings: __________________________
Has anybody ever diagnosed you with any of the following? Peptic Ulcer Disease | Gallstones | Liver Disease | Hepatitis | Cirrhosis | Pancreatitis | Colitis | Diverticulosis | Colon Polyps | Cancer: Stomach, Colon, Liver, Pancreatic | Hemorrhoids

**Heart, Blood Vessels**
Chest pain (Angina) | Chest pressure | Heart attack | Short of breath at night | Heart murmur | Rapid heartbeat that required treatment | Swollen ankles | Leg cramps at night | Leg cramps when walking | Rheumatic fever | Congenital heart disease

**General**
Fever | Sweats | Weakness | Fatigue

**Lungs**
Cough every day | Cough, produce sputum (phlegm) most day’s | Blood in your sputum | Pneumonia | Bronchitis | Emphysema | Pleurisy | Tuberculosis | Asthma | Short of breath with activity | Short of breath at rest | Frequent colds

**Genitourinary**
Frequent urination | Painful urination | Urinate at night | Blood in urine

**Genitourinary: Men**
Difficulty starting/stopping urination | Sexual performance problems | Elevated prostate blood test (PSA) | Prostate biopsy | Swollen/painful testicle | Do you consistently use contraceptives

**Genitourinary: Women**
Age started menstruating: | Irregular or painful menstruation | Date of last period ____ | Age stopped menstruating ____ | Painful intercourse | Bleeding following intercourse | Endometriosis | Pregnant now | Birth Control Method ___________

**Neurological**
Headaches | Double vision | Blurred vision | Weakness in extremity | Numbness | Forgetfulness | Confusion

**Hematologic**
Bruise or bleed easily | Anemic | Take aspirin or nonsteroid anti-inflammatory (Motrin, Advil, Alieve) | Swollen glands

**Eyes**
Lost vision | Wear glasses | Cataract | Glaucoma

**Ears**
Lost hearing | Ringing in your ears | Hearing aid

**Sinuses**
Sinus trouble | Nosebleeds

**Mouth**
Dental problems | Wear dentures | Sore tongue

**Neck**
Swollen glands

**Breasts**
Nipple discharge | Breast lumps | Cystic breast disease | Breast infection | Hormone replacement therapy

Date of last Mammogram _____________

**Skin**

Excessive suns exposure | Blistering/burns | Use sunscreen | Dark or pigmented skin lesion | Dark or pigmented skin lesion removed | Melanoma | Bleeding skin lesion | Psoriasis | Chronic rash | Vitiligo | Birthmark |

**Extremities & Back**

Arthritis | Back pain | Broken bone | Swollen joints | Joint pain

**Activities you find difficult**

Bathing | Dressing | Eating | Housekeeping | Using toilet | Walking

**Medical Equipment**

Do you use a: Cane | Oxygen | Catheter | Walker | Wheelchair | Nebulizer