



<b>Social History</b> (write answers and check spaces as needed):	
Employment	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> In School <input type="checkbox"/> Permanently Disabled <input type="checkbox"/> Partially Disabled Your occupation:
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Partner
Sexual Orientation	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Same sex <input type="checkbox"/> Both sexes <input type="checkbox"/> Transgender <input type="checkbox"/> Other Comments:
Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Same partner for ___ years <input type="checkbox"/> Multiple partners With <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both
Education	<input type="checkbox"/> High School <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's <input type="checkbox"/> Doctorate <input type="checkbox"/> or years completed:
Smoking	<input type="checkbox"/> Never <input type="checkbox"/> Previous (past) smoker <input type="checkbox"/> Recently stopped <input type="checkbox"/> Smoking now <input type="checkbox"/> # per day _____ for how many years _____ <input type="checkbox"/> Quit (date) _____ <input type="checkbox"/> Smoked ___ packs per day for ___ years <input type="checkbox"/> Chew tobacco <div style="text-align: right;">Frequency _____</div>
Alcohol	<input type="checkbox"/> Drink alcohol - Type: _____ Frequency: _____ <input type="checkbox"/> Never drink <input type="checkbox"/> Recovering alcoholic <input type="checkbox"/> Stopped drinking alcohol <input type="checkbox"/> Alcohol use during pregnancy
Caffeine	<input type="checkbox"/> No <input type="checkbox"/> Yes - how much _____
Regular Exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes - Type: _____ Frequency: _____
Seatbelt Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Living in	<input type="checkbox"/> Home <input type="checkbox"/> Apartment <input type="checkbox"/> Hospice <input type="checkbox"/> Nursing home <input type="checkbox"/> Assisted living facility <input type="checkbox"/> Halfway house <input type="checkbox"/> Homeless <input type="checkbox"/> Also Homebound
Living Environment	<input type="checkbox"/> Secure and Safe <input type="checkbox"/> Fear of other Occupants
Leisure, Recreational or Sports Activities	
Learning Disability [PMH]	
Recreational Drug Use/Substance Abuse [PMH]	<input type="checkbox"/> No <input type="checkbox"/> Yes - Type: _____ Route: _____ Frequency: _____ _____ <input type="checkbox"/> Past Drug Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on a special diet?	<input type="checkbox"/> No <input type="checkbox"/> Yes - <b>Details:</b> _____

Name	
MRN	DOB

Past Medical History: ONLY CHECK YES IF APPLIES TO YOU					
History of:		When?	History of:		When?
Alcohol Abuse Problem	<input type="checkbox"/> Yes		Cancer Ovarian	<input type="checkbox"/> Yes	
Anemia	<input type="checkbox"/> Yes		Cancer Uterine	<input type="checkbox"/> Yes	
Anxiety	<input type="checkbox"/> Yes		Cancer Colorectal	<input type="checkbox"/> Yes	
Arthritis (Rheumatoid)	<input type="checkbox"/> Yes		Cancer Lung	<input type="checkbox"/> Yes	
Arthritis (Osteo or Degenerative)	<input type="checkbox"/> Yes		Cancer Colon	<input type="checkbox"/> Yes	
Asthma	<input type="checkbox"/> Yes		Cancer Prostate	<input type="checkbox"/> Yes	
Bleeding Tendency	<input type="checkbox"/> Yes		Cancer Skin Melanoma	<input type="checkbox"/> Yes	
Bladder/Urinary infection	<input type="checkbox"/> Yes		Cancer Skin Basal Cell	<input type="checkbox"/> Yes	
Blood Clots: Legs (deep vein thrombosis)	<input type="checkbox"/> Yes		Cancer Other	<input type="checkbox"/> Yes	
Blood clots: Lung (pulmonary embolus)	<input type="checkbox"/> Yes		Cirrhosis	<input type="checkbox"/> Yes	
Blood Transfusion	<input type="checkbox"/> Yes		COPD/Emphysema	<input type="checkbox"/> Yes	
Breast Problems	<input type="checkbox"/> Yes		Cancer Lung	<input type="checkbox"/> Yes	
Cancer Breast	<input type="checkbox"/> Yes		Diabetes	<input type="checkbox"/> Yes	
Depression	<input type="checkbox"/> Yes		Low Back Pain	<input type="checkbox"/> Yes	
Epilepsy	<input type="checkbox"/> Yes		Liver Disease Type:	<input type="checkbox"/> Yes	
Gall Bladder Disease	<input type="checkbox"/> Yes		Migraine	<input type="checkbox"/> Yes	
Glaucoma	<input type="checkbox"/> Yes		Multiple Sclerosis	<input type="checkbox"/> Yes	
Gout	<input type="checkbox"/> Yes		Osteoporosis/Osteopenia	<input type="checkbox"/> Yes	
Hay Fever	<input type="checkbox"/> Yes		Pap Smear Abnormal	<input type="checkbox"/> Yes	
Heart Attack	<input type="checkbox"/> Yes		Parkinson's Disease	<input type="checkbox"/> Yes	
Heart Disease	<input type="checkbox"/> Yes		Pelvic Inflammatory Disease	<input type="checkbox"/> Yes	
Heart Failure	<input type="checkbox"/> Yes		Parkinson's Disease	<input type="checkbox"/> Yes	
Heartburn/GERD/Reflux	<input type="checkbox"/> Yes		Kidney Stone	<input type="checkbox"/> Yes	

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Past Medical History: <b>ONLY CHECK YES IF APPLIES TO YOU</b>					
History of:		When?	History of:		When?
High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes		Kidney Failure, Type:	<input type="checkbox"/> Yes	
High Cholesterol (Hypercholesterolemia)	<input type="checkbox"/> Yes		Shingles	<input type="checkbox"/> Yes	
Hives/Urticaria	<input type="checkbox"/> Yes		Skin Condition	<input type="checkbox"/> Yes	
Hepatitis B	<input type="checkbox"/> Yes		Sleep Apnea	<input type="checkbox"/> Yes	
Hepatitis C	<input type="checkbox"/> Yes		Stroke	<input type="checkbox"/> Yes	
			Thyroid - Low (Hypothyroidism)	<input type="checkbox"/> Yes	
			Sexually Transmitted Disease: <input type="checkbox"/> Chlamydia infection (penile or vaginal) <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Other venereal disease <input type="checkbox"/> HPV	<input type="checkbox"/> Yes	

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<b>Family History</b>					
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?					
<b>History of (check if "yes"):</b>	<b>Father</b>	<b>Mother</b>	<b>Brother</b>	<b>Sister</b>	<b>Other</b>
Alcohol Abuse Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Ovarian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Uterine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Colorectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Skin Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Skin Basal Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure (hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol (hypercholesterolemia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease, Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Failure, Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Adult Prevention History</b>		
<b>Test</b>	<b>Test Result</b>	<b>Where &amp; Approx Date</b>
Bone Density (BXA)		
BRCA Testing		
Mammography		
Pap Smear		
Colon cancer screen with colonoscopy, barium enema, flexible sigmoidoscopy or stool cards		

Name	
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Adult Prevention History (Cont.)		
Test	Test Result	Where & Approx Date
Colorectal Screening		
If you have asthma, COPD or emphysema: Pulmonary Function (Breathing) Test		
If you have diabetes: Foot Exam <input type="checkbox"/> Yes <input type="checkbox"/> No Dilated eye examination <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>VACCINATIONS:</b>		
H1N1 (Swine Flu)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Herpes zoster (shingles)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Human Papillomavirus (HPV)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Influenza (Flu)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Measles, Mumps, Rubella (MMR)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Meningococcal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumococcal (pneumonia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tetanus or Tetanus/diphtheria (Td) or Tetanus/Diphtheria/Pertussis (Tdap)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Varicella (chicken pox)	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Past Surgical History		
Surgery:	Description (if known):	Approx. Date
Appendix		
Bladder		
Blood vessel		
Eye		
Ear		
Gall Bladder		
Heart		
Joint		
Pelvic		
Prostate		
Stomach		
Skin		
Uterus (Cesarean, Hysterectomy)		
Other		

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Current Female Health History				
Last pap smear	Date: Results:	Number of pregnancies		
Last mammogram	Date: Results:	Number of deliveries		
Age @ Menstrual Period		Number of Miscarriages/ abortions		
1 <sup>st</sup> Day of Last menstrual period	Date:	Method of contraceptive/ how long?	<input type="checkbox"/> Yes	Type: Any Problems with Method?
Frequency of Periods		Gynecologic Problem	<input type="checkbox"/> Yes	
Irregular or missed menstrual periods	<input type="checkbox"/> Yes	Menopausal	<input type="checkbox"/> Yes How Long?	

Current Male Health History				
Prostate Problem Type:	<input type="checkbox"/> Yes	Have you been counseled about the pros/cons of PSA prostate cancer screening?	<input type="checkbox"/> Yes Date:	
Urine Flow Problem	<input type="checkbox"/> Yes	Have you had a prostate biopsy?	<input type="checkbox"/> Yes Date:	Results:

Review of Systems		DATE: _____
Patient: please check below if you have any of the following problems:		
SYSTEM	DESCRIPTION	PROVIDER COMMENTS (Document for all positive findings)
1. General <input type="checkbox"/> No Problems	<input type="checkbox"/> Weight Loss # lbs: ____ <input type="checkbox"/> Weight Gain # lbs: ____ <input type="checkbox"/> Fever <input type="checkbox"/> Other:	
2. Eyes <input type="checkbox"/> No Problems	<input type="checkbox"/> Glasses/Contact Lenses <input type="checkbox"/> Vision Changes <input type="checkbox"/> Other:	
3. Head & Neck Ears, Nose, Mouth, Throat <input type="checkbox"/> No Problems	<input type="checkbox"/> Headache <input type="checkbox"/> Stiffness <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Other:	

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Patient: please check below if you have any of the following problems:		
4. Heart/Circulation <input type="checkbox"/> No Problems	<input type="checkbox"/> Difficulty Breathing when lying down <input type="checkbox"/> Swelling in legs <input type="checkbox"/> Irregular heart rate <input type="checkbox"/> Other:	
5. Lungs/Breathing <input type="checkbox"/> No Problems	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Other:	
6. Digestion/Bowels <input type="checkbox"/> No Problems	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Other:	
7. Kidneys/Bladder <input type="checkbox"/> No Problems	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Urgency <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Incomplete Emptying <input type="checkbox"/> Incontinence <input type="checkbox"/> Other:	
8. Reproductive <input type="checkbox"/> No Problems	<input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Pain with Intercourse <input type="checkbox"/> Other:	
9. Muscles/bones <input type="checkbox"/> No Problems	<input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Other:	
10. Skin/Breasts <input type="checkbox"/> No Problems	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Breast Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Lump <input type="checkbox"/> Bleeding <input type="checkbox"/> Other:	
11. Nervous System <input type="checkbox"/> No Problems	<input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Problems Walking <input type="checkbox"/> Other:	
12. Mental/Emotional <input type="checkbox"/> No Problems	<input type="checkbox"/> Anxiety <input type="checkbox"/> Crying <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Other:	
13. Endocrine <input type="checkbox"/> No Problems	<input type="checkbox"/> Diabetes - Type: _____ <input type="checkbox"/> Hot flashes <input type="checkbox"/> Low Thyroid <input type="checkbox"/> Overactive Thyroid <input type="checkbox"/> Other:	
14. Blood/Lymphatic <input type="checkbox"/> No Problems	<input type="checkbox"/> Bruises <input type="checkbox"/> Clotting Problems <input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Other:	
Reason for Visit Today: _____		
Health Concerns Today: _____		
Completed by: <input type="checkbox"/> Patient <input type="checkbox"/> Other - Relationship to Patient: _____		
Additional Provider Comments:		

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