Patient Information

TODAY'S DATE: _________

Legal name: Last ____________________ **First** ________________ **MI** ____ **Preferred name:** _______ **BIRTHDATE:** __________

Legal gender: ______________ **Gender identity:** ______________ **Preferred pronoun:** ______________

Primary care provider (PCP): ____________________________________ **PCP Phone:** _______________

Preferred pharmacy and location: ____

What are your main reasons for coming to the clinic today? *Please note priority.* ☐ Establish primary care

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Allergies, Medications & Supplements

Allergies: ☐ No Known Allergies ☐ Epi pen?

Allergen	Reaction	Severity	Age

Medications: ☐ None ☐ See attached

Name	Dose	Frequency	Reason

Do you use regularly: ☐ Tylenol/acetaminophen ☐ Advil/ibuprofen ☐ Aleve/naproxen ☐ Aspirin ☐ Oral contraceptive pill

Supplements/Vitamins: ☐ None ☐ See attached

Name & brand	Dose	Frequency	Reason

Medical History

Please take a minute to think about your health throughout your life. List all known **illnesses / diagnoses**, **major events (surgeries, hospitalizations, accidents)** and **imaging.** If applicable, include providers' name and contact info. involved in your care.

Diagnoses	Date	Specialist name	Clinic contact info.

Major events: surgeries, hospitalizations, accidents (tonsils, appendix, GB, heart, hyst, etc.)	Date	**Imaging** (x-ray, MRI, CT, ultrasound, ECG, echo, etc.)	Date

Preventive Health Care

Screening tests	Date	Results?
Annual physical exam		
PAP smear (cervical / anal)		
HPV co-testing w/PAP		
Mammogram		
Colonoscopy		
PSA blood test / Prostate exam		
Bone Density Scan (DEXA)		
Cholesterol		
Hepatitis C testing		
Dental exam		
Eye exam		
Diabetic foot exam		

Vaccines	Date	Name of vaccine?
TDaP or Tetanus booster		
Flu shot		
Pneumonia		
Shingles / Chickenpox		
Hepatitis A		
Hepatitis B		
Human Papilloma Virus (HPV)		
Other vaccine		
Other vaccine		

Did you receive standard childhood vaccines? ☐ Yes ☐ No
(polio, measles, mumps, rubella, tetanus, diptheria, whooping cough)

Family Health History

Please list any known family history of **stroke**, **heart problems**, **high cholesterol, high blood pressure, diabetes** and **cancer.** Include other significant health problems such as osteoporosis, thyroid problems, mental health, dementia and autoimmune diseases if able.

Relationship	**~ Age if living**	**~ Age of death**	**Medical History**
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Sibling			
Sibling			
Child			
Child			
Child			

Did any other family members (aunts, uncles, cousins) have COLON CANCER or COLON POLYPS? ☐ Yes ☐ No

Social History

What is your living situation? ______________________________

Do you live alone? ☐ Yes ☐ No Do you have stable housing? ☐ Yes ☐ No Do you have pets? ☐ Yes ☐ No ______

What is your occupation? ______________________ ☐ Student ☐ Retired ☐ Disabled ☐ None

What are your hobbies? ______________________

What are your religious or spiritual beliefs? ______________

Do you exercise? ☐ Yes ☐ No *Please specify:* ______________ *How often?* ________ *For how long?* ______

Is stress a major problem for you? ☐ Yes ☐ No ☐ Unsure

Do you feel you have enough support from friends or family? ☐ Yes ☐ No

Tobacco, Alcohol & Drug Use

Tobacco use: ☐ Never ☐ Current ☐ Past ☐ Passive (around smoke)

If ever, what kinds? ☐ Cigarettes ☐ Cigars ☐ E-cigarettes ☐ Chew ☐ Snuff

Cigarettes per day: ________ # Years smoked: ______ Quit date: _____

Alcohol intake: ☐ Never ☐ Current ☐ Past

If ever, what kinds? ☐ Beer ☐ Wine ☐ Liquor

Drinks per week: ________ Quit date: _____

Recreational drugs: ☐ Never ☐ Current ☐ Past How often did / do you use? ________ Quit date: _____

If ever, what kinds? ☐ Marijuana ☐ Hallucinogens (LSD, mushrooms)

☐ Cocaine ☐ Methamphetamines ☐ Other: ______

☐ Opioids ☐ Heroin ☐ Benzodiazepines ______

Have you ever injected drugs: ☐ Yes ☐ No

Relationship Status

Check all that apply: ☐ Single ☐ Married ☐ Domestic Partner ☐ Long-term ☐ Monogamous ☐ Polyamorous ☐ Open Relationship

Sexual History

What is your sexual orientation? ☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Other ______

Have you ever had sex with another person? ☐ Yes ☐ No

If yes:

Are you currently sexually active? ☐ Yes ☐ No

In your life, your partners' anatomy has been: ☐ Penis ☐ Vagina ☐ Both

Do you use safe sex practices? ☐ Yes ☐ No If yes, please specify: ______________

Do you or any of your partners use birth control? ☐ Yes ☐ No If yes, what kinds? ______________

Are you interested in contraceptive counseling? ☐ Yes ☐ No If yes, today? Questions? ______________

Have you ever tested positive for an STI/STD? ☐ Yes ☐ No If yes, what & when was it treated? ________

Any concerns about your sexual function? ☐ Yes ☐ No ☐ Unsure Want to discuss this today? ☐ Yes ☐ No

Have you ever been forced into sexual acts against your will? ☐ Yes ☐ No Want to discuss this today? ☐ Yes ☐ No

Dietary History

Do you follow a specific diet or avoid any foods? ______________________________

Typical diet:

Breakfast: ______________________ Snacks: ______________________

Lunch: ______________________ Beverages: ______________________

Dinner: ______________________ Water total amount: ______ Caffeine: ______

Safety Screening

Do you wear seatbelts? ☐ Yes ☐ No

Do you use helmets / safety equipment? ☐ Yes ☐ No

Do you have access to adequate food? ☐ Yes ☐ No

Do you feel physically safe from abuse? ☐ Yes ☐ No

Do you ever feel unsteady or off balance? ☐ Yes ☐ No

Have you fallen in the past year? ☐ Yes ☐ No

Are you exposed to any toxins? ☐ Yes ☐ No

Are there guns in your home? ☐ Yes ☐ No

Review of Systems: Please check C for current and recent symptoms. Check P for symptoms you've had in the past.

System	C	P	Symptoms	C	P	Symptoms	C	P	Symptoms	Comments, other diagnoses, etc.
General & Endocrine	☐	☐	Fatigue	☐	☐	Recent weight gain	☐	☐	Chills	
	☐	☐	Decreased appetite	☐	☐	Feel too cold or hot	☐	☐	Night sweats	
	☐	☐	Recent weight loss	☐	☐	Fever	☐	☐	Recent foreign travel?	
							☐	☐	Increased thirst	
Eyes / Ears / Nose Mouth / Throat	☐	☐	Wear glasses/contacts	☐	☐	Ear plugging	☐	☐	Bleeding gums	
	☐	☐	Vision changes	☐	☐	Vertigo	☐	☐	Dental problems	
	☐	☐	Blind spots	☐	☐	Seasonal allergies	☐	☐	Dentures	
	☐	☐	Double vision	☐	☐	Snoring	☐	☐	Swelling in neck	
	☐	☐	Eye pain	☐	☐	Sinus congestion	☐	☐	Pain in neck	
	☐	☐	Hearing loss	☐	☐	Bloody noses	☐	☐	Difficulty swallowing	
	☐	☐	Tinnitus / ringing	☐	☐	Face pain /pressure	☐	☐	Sore throat	
	☐	☐	Ear pain	☐	☐	Mouth pain	☐	☐	Sleep apnea	Date of sleep study?
Head	☐	☐	Headache	☐	☐	Head injury	☐	☐	Loss of consciousness	Date of head injury:
	☐	☐	Migraine	☐	☐	Concussion				
Neurology	☐	☐	Changes in memory	☐	☐	Seizures	☐	☐	Numbness	
	☐	☐	Changes in speech	☐	☐	Spasms / twitches	☐	☐	Tingling	
	☐	☐	Changes in walking	☐	☐	Tremors	☐	☐	Weakness	
Heart / Vascular	☐	☐	Chest pain	☐	☐	Lightheadedness	☐	☐	Rheumatic fever	Last echocardiogram:
	☐	☐	Palpitations	☐	☐	Cold fingers or toes	☐	☐	Decrease in stamina	Last ECG:
	☐	☐	Heart murmur	☐	☐	Swelling in legs				Can you walk > 2 flights of stairs?
	☐	☐	Fainting	☐	☐	Varicose veins				
Lung	☐	☐	Shortness of breath	☐	☐	Wheezing	☐	☐	Difficulty lying flat	Last spirometry:
	☐	☐	Coughing	☐	☐	Bloody cough	☐	☐	Asthma	
Gastro/ Digestion / Stomach / Colon / Rectum	☐	☐	Abdominal pain	☐	☐	Excess burping	☐	☐	Dark tarry stool	# of bowel movements daily: _____
	☐	☐	Heart burn	☐	☐	Excess gas	☐	☐	Mucous in stool	
	☐	☐	Nausea	☐	☐	Diarrhea	☐	☐	Parasitic infection	Consistency of stool: *check any*
	☐	☐	Vomiting	☐	☐	Constipation	☐	☐	Hemorrhoids	☐ watery ☐ soft ☐ well-formed
	☐	☐	Bloating	☐	☐	Blood in stool				☐ compacted ☐ pebbles ☐ varies
Urinary	☐	☐	Increased urination	☐	☐	Pain with urination	☐	☐	Slowed stream	
	☐	☐	Urgent urination	☐	☐	History of stones	☐	☐	Wait for urine	
	☐	☐	Urine leakage	☐	☐	Incomplete emptying	☐	☐	Urination at night >2x	
Reproductive	☐	☐	Decreased libido	☐	☐	Irregular cycle	☐	☐	Vaginal dryness	Age at first period ____________
	☐	☐	Hernias	☐	☐	Spotting before period	☐	☐	Vaginal pain	Date of most recent period ______
	☐	☐	Testicular injury	☐	☐	Heavy bleeding	☐	☐	Pelvic pain	Length between periods ________
	☐	☐	Testicular mass	☐	☐	Heavy cramping	☐	☐	Pain with intercourse	Age of menopause ____________
	☐	☐	Testicular self-exams	☐	☐	Infertility	☐	☐	Hotflashes	Number of pregnancies: _______
	☐	☐	Penis pain	☐	☐	Vaginal/genital lesions	☐	☐	Nightsweats	• Miscarriages: ______
	☐	☐	Penis discharge	☐	☐	Vaginal itching/burning	☐	☐	Abnormal PAP or HPV	• Abortions: ______
	☐	☐	Penis/genital lesions	☐	☐	Vaginal discharge/odor				• Full term births: ______
	☐	☐	Erectile dysfunction							• Vaginal? __ Cesarean? __
Breast	☐	☐	Breast pain	☐	☐	Breast skin changes	☐	☐	Nipple discharge	
	☐	☐	Breast mass	☐	☐	Breast dimpling	☐	☐	Breast self-exams	
Blood / Lymph / Immune	☐	☐	Easy bleeding	☐	☐	Clotting problems	☐	☐	Swollen lymph nodes	
	☐	☐	Easy bruising	☐	☐	History of transfusion	☐	☐	Get sick often	
	☐	☐	Iron deficiency	☐	☐	Allergies	☐	☐	Chronic infections	
Skin / Hair / Nails	☐	☐	New skin lesions	☐	☐	Rash	☐	☐	Psoriasis	Do you see a dermatologist?
	☐	☐	Skin wounds	☐	☐	Itching	☐	☐	Hair loss	☐ Yes ☐ No
	☐	☐	Changing moles	☐	☐	Eczema	☐	☐	Nail changes	
							☐	☐	Jaundice / yellowing	
Mental health	☐	☐	Depression	☐	☐	Difficult falling asleep	☐	☐	Eating disorder	Do you see a counselor?
	☐	☐	Anxiety	☐	☐	Waking in the night	☐	☐	Binging	☐ Yes ☐ No
	☐	☐	Panic attacks	☐	☐	Can't get back to sleep	☐	☐	Purging	
	☐	☐	PTSD	☐	☐	Paranoia	☐	☐	Restricting	
Muscles / Bones	☐	☐	Joint pain	☐	☐	Muscle cramps	☐	☐	Difficulty moving	Are you in pain? ☐ Yes ☐ No
	☐	☐	Joint stiffness	☐	☐	Back pain	☐	☐	Difficulty walking	Severity of pain (1-10): _____
	☐	☐	Muscle pain	☐	☐	Neck pain				(0 = no pain, 10 = most severe pain)