ATTENTION NEW PATIENTS – PLEASE BRING A LIST OF YOUR MEDICATIONS WITH YOU TO YOUR APPOINTMENT

Name: _____ **Date of birth:** _____ **Date:** _____

Local Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Pharmacy Address, City, Zip: _____

Mail order pharmacy information (if applicable): _____

Place of birth: _____ **Highest grade completed:** _____ **Religion:** _____

Marital status: ___ Single ___ Married ___ Divorced ___ Domestic partnership ___ Widowed

Occupation: ___ Working (Current occupation _____) ___ Student ___ Homemaker
___ Retired (Former occupation _____) ___ Disabled ___ Unemployed

PAST MEDICAL HISTORY (check if appropriate):

Yourself		Yourself		Yourself	
□	Alpha-1 Antitrypsin deficiency	□	Heart attack	□	Pneumonia
□	Arthritis	□	Hepatitis	□	Renal disorders
□	Asthma	□	Hiatal Hernia	□	Restless Legs Syndrome
□	Blood clots	□	High blood pressure	□	Rheumatic fever
□	Blood transfusion	□	HIV infection	□	Sarcoidosis
□	CAD	□	Insomnia	□	Scleroderma
□	Cancer	□	Lung disease	□	Seizure disorder
□	CHF	□	Lung mass	□	Sleep apnea
□	Chronic bronchitis	□	Lupus	□	Snoring
□	COPD	□	Narcolepsy	□	Stroke
□	Diabetes	□	Osteoporosis	□	Thyroid disease
□	Emphysema	□	Other heart disease	□	Tuberculosis
				□	Ulcers

FAMILY MEDICAL HISTORY (check if appropriate):

Family member		Family member	
□	Arthritis	□	Lung disease
□	Asthma	□	Lupus
□	Blood clots	□	Osteoporosis
□	CAD	□	Renal disorders
□	Diabetes	□	Sarcoidosis
□	Emphysema	□	Sleep apnea
□	Heart attack	□	Stroke
□	High blood pressure	□	Alpha 1 Antitrypsin Deficiency (specify) □ Father □ Mother □ Brother □ Sister

LIST ALL OPERATIONS:

	Date	Hospital	Procedure
1.			
2.			
3.			

HAVE YOU BEEN ADMITTED TO THE HOSPITAL IN THE LAST TWO YEARS?

	Date	Reason
1.		
2.		
3.		

LIST ALLERGIES: _____

Name: _____ **Date of birth:** _____ **Date:** _____

CURRENT HABITS: ____ I **currently** smoke ___ packs per day for ___ years ____ I **never** smoked
____ I **formerly** smoked ___ packs per day for ___ years; I quit smoking (when?) _____

ALCOHOL CONSUMPTION: _____ # of drinks per (circle one) day/week/month

PATIENTS OVER 65 – Have you received a pneumonia vaccine? ☐ Yes ☐ No If yes, date: _____

REVIEW OF SYSTEMS – (check symptoms you experienced):

CONSTITUTIONAL:
- ☐ change in weight
- ☐ fever/chills
- ☐ night sweats

RESPIRATORY:
- ☐ shortness of breath
- ☐ cough
- ☐ coughing up blood
- ☐ wheezing

CARDIAC:
- ☐ chest pain/discomfort
- ☐ racing/irregular heartbeat
- ☐ ankle swelling
- ☐ aching legs when walking

ALLERGIC:
- ☐ allergies to dust, pollen
- ☐ allergies to animals
- ☐ seasonal hay fever

SLEEP:
- ☐ excessive sleepiness
- ☐ insomnia
- ☐ loud snoring
- ☐ leg pain at night

EYES, EARS, NOSE, THROAT:
- ☐ ringing in ears
- ☐ frequent bloody nose
- ☐ sinus infection
- ☐ hoarseness

GASTROINTESTINAL:
- ☐ nausea/vomiting
- ☐ difficulty swallowing
- ☐ heartburn
- ☐ abdominal pain

NEUROLOGIC:
- ☐ frequent headache
- ☐ numbness/tingling
- ☐ seizures

HEMATOLOGIC:
- ☐ anemia
- ☐ enlarged lymph nodes
- ☐ blood clots

PSYCHIATRIC:
- ☐ anxiety
- ☐ depression
- ☐ drug abuse
- ☐ alcohol abuse

☐ **NONE OF THE ABOVE SYMPTOMS APPLY TODAY**

I have reviewed the past medical history, medications, social history, family history, and review of systems during this visit.

_____	_____	_____	_____
Patient	Physician	Clinical staff member	Date