Hendricks Regional Health

Patient name:_____ DOB:_____ Date:_____

Current Medications

Please list all medications you are taking at this time, include vitamins, topicals, injections, supplements & herbal or provide a complete list (use bottom of form if needed)

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Why do you take this medication?
1			
2			
3			
4			
5			
6			
7			
8			

PHARMACY_____ (for local prescriptions)

Allergies-*Please list all medications and environmental agents you are allergic to. Please include what type of reaction you have (hives, nausea, breathing problems, etc.) and severity.*

_____
_____
_____
_____

Past Medical History- *Please include all medical problems such as diabetes, high blood pressure, etc.*

_____
_____
_____
_____

Past Surgical History- *Please list all procedures including surgeries, colonoscopies, heart catheterizations, etc. And approximate year performed.*

_____
_____
_____
_____

PRIMARY CARE PHYSICIAN_____ address_____

Phone number_____

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Patient name:_____ DOB:_____ Date:_____

Family Medical History: unknown ____ adopted ____

Mother ☐ Cancer: type _____ ☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Father ☐ Cancer: type _____ ☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Sister ☐ Cancer: type _____ ☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Brother ☐ Cancer: type _____ ☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Maternal Grandmother ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Maternal Grandfather ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Paternal Grandmother ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Paternal Grandfather ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Maternal specify Aunt/uncle ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

Paternal specify Aunt/Uncle ☐ Cancer: type _____
☐ stroke ☐ heart disease ☐diabetes
Other _____ ☐dementia ☐blood/genetic disorder

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Social History

SMOKING/NICOTINE

Do you currently smoke? Yes/No Have you ever smoked? Yes/No

If Yes: how many years_____ If Yes: When did you quit:_____

how many cigarettes/packs per day_____

Do you currently or have you ever used any other nicotine products such as patches or gum? Current/Former/Never

Have you ever or do you currently use any type of smokeless tobacco? Current/Former/Never chew/snuff

Have you ever or do you currently vape or use e cigarettes? Current/Former/never

ALCOHOL

Do you currently drink alcohol? Yes/No/never

If Yes: how many drinks/month_____

SUBSTANCE USE

Have you ever used illegal substances? CIRCLE--- In the past/ currently/ never

What type _____ & How often_____

If in the past When did you quit _____

SEXUAL ACTIVITY:

Are you sexually active: Yes/No Male/female partner Women: first day of last period_____

If sexually active could you be pregnant yes/no/na What birth control method do you use?_____

SOCIOECONOMIC

Are you employed? Yes/No Retired? yes/no Disabled? yes/no

If Yes: What type of work do or did you do or title _____

DEMOGRAPHICS

Marital status

Are you: Single Married Legally Separated Divorced Widowed Significant other

Spouse/Significant other's Name _____

Number of living Biologic Children_____ number of living stepchildren_____ number of adopted children_____

SOCIAL DOCUMENTATION

Do you participate in any physical activity ? Yes/No/never

If Yes, what and how often _____

Do you care for any large animals (over 40 pounds)? Yes/no type_____

Do you have to help care for disabled dependents or family members? Yes/no if yes who?_____

If Yes does the care involve physical lifting Yes/no

Obstetric history-*females only*

Number of pregnancies _____ Number of vaginal deliveries _____ Number of miscarriages_____

Number of cesarean sections _____ Number of abortions _____

Review of Systems (symptoms within the last 7 days)

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Constitution
Fatigue YES NO
Fever YES NO
Unexpected Weight Change YES NO
Other_____ YES NO

Ear/Nose/Throat
Congestion YES NO
Hearing Loss YES NO
Nosebleeds YES NO
Sinus Pain YES NO
Sore Throat YES NO

Eyes
Visual Disturbance YES NO

Respiratory
Cough YES NO
Shortness of breath YES NO
Wheezing YES NO
Other_____ YES NO

Cardiovascular
Chest Pain YES NO
Leg Swelling YES NO
Palpitations YES NO
Other_____ YES NO

Gastroenterology
Abdominal Pain YES NO
Constipation YES NO
Nausea YES NO
Vomiting YES NO
Diarrhea YES NO
Lactose Intolerant YES NO

Musculoskeletal
Joint Pain YES NO
Back Pain YES NO
Difficulty Walking YES NO
Joint Swelling YES NO
Muscle Pain YES NO

Skin
Color Change YES NO
Rash YES NO
Wound YES NO

Immunosuppressed
Immunocompromised YES NO
Other_____ YES NO

Neurological
Dizziness YES NO
Facial Asymmetry YES NO
Headaches YES NO
Light Headedness YES NO
Numbness YES NO
Seizure YES NO
Fainting YES NO
Weakness YES NO

Hematologic
Bruises easily YES NO
Other_____ YES NO

Psychiatric
Confusion YES NO
Dysphoric Mood YES NO
Nervous/Anxiety YES NO
Suicidal Ideas YES NO

Endocrine
Cold Intolerance YES NO
Heat Intolerance YES NO
Other_____ YES NO

Urinary/Reproductive
Difficulty Urinating YES NO
Painful Urination YES NO
Frequent Urination YES NO
Blood in Urine YES NO
Urgency YES NO

Female
Vaginal Bleeding YES NO
Vaginal Discharge YES NO