**Patient Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronoun \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Y or N** | **CONCERNS** | **Y or N** | **CONCERNS** | **Y or N** | **CONCERNS** |
|  | ANEMIA |  | HEARING LOSS |  | PROSTATE |
|  | ASTHMA |  | HEART DISEASE |  | SLEEP APNEA |
|  | CANCER |  | BLOOD PRESSURE |  | STOMACH  |
|  | DIABETES |  | CHOLESTEROL |  | STROKE |
|  | DIET/NUTRITION |  | KIDNEYS |  | THYROID |
|  | EMPHYSEMA |  | MIGRAINE  |  | SEXUAL |
|  | GLAUCOMA |  | 02 DEPENDENT |  | FALL RISK |
|  | ANXIETY |  | DEPRESSION |  | NOT LISTED |

**PLEASE LIST ALL ALLERGIES**

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| --- | --- | --- | --- |
| **MEDICATIONS** | **REACTION** | **FOODS** | **REACTION** |
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**SURGICAL HISTORY**

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| --- | --- |
| **PROCEDURE** | **YEAR** |
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**SIGNIFICANT FAMILY HISTORY**

|  |  |
| --- | --- |
| **MEDICAL ISSUE** (cancer, heart disease, high blood pressure, etc.) | **FAMILY MEMBER** (mother, father, sibling) |
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 Continued

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**TOBACCO USE**

Do you smoke or chew tobacco? Yes\_\_\_ No\_\_\_ # of years\_\_\_\_\_ YEAR QUIT\_\_\_\_\_

**EXAM/PROCEDURE** (year)

PAP SMEAR\_\_\_\_\_ BONE DENSITY TEST\_\_\_\_\_ PHYSICAL EXAM\_\_\_\_\_ PROSTATE EXAM\_\_\_\_\_

LAB WORK \_\_\_\_\_ OTHER NOT LISTED\_\_\_\_\_

**MEDICATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION**  | **DOSE** | **HOW OFTEN** (morning, bed time) | **REASON** (diabetes, blood pressure, etc.) |
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**Any other information not listed, please note below**

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