MEDICAL HISTORY-(New Patients/Consults/Full physicals) DATE:

Patient name Birthday: Age:

Address: City State Zip

Gender Male Female

Home phone Work phone

Emergency contact& phone: Referred by:

Chief Complaint:

Location:
Duration:
Date symptoms began:
Recently symptoms have been: continuous/periodic
Severity: mild, moderate, severe
Quality: burning, stabbing, cramping, sharp
Modifying factors:
Associated signs/symtoms:
(Extended History-document at least 4 of these elements)

Patient medical history:(Positive= Circle, Negative=(-), also indicate duration of illness i.e. 2 years)

Diabetes Hypertension Heart disease Arthritis Seizures Asthma
Cancer (Type): Venereal diseases Bleeding tendency
Depression Anxiety Drug or alcohol addiction Other:

Previous Hospitalizations/Surgeries/Serious injuries(Include when?):

Appendectomy Tonsillectomy Gallbladder Other

Medications: Drug name	Dosage	Frequency

Allergies: Medication	Type of reaction

Patient social history:

Marital status:	Single	Married	Divorced	Widowed	
Use of alcohol:	Never	Rarely	Moderate	Daily	
Use of tobacco:	Never	Previously, but quit		years ago.	
	Currently Smoke	Packs/day			
Use of drugs:	Never	Type/frequency			
Excessive exposure at home all work to:		Fumes Dust	Solvents	Noise Other	
Mental work:	Light	Moderate	Heavy	Hours per day	None
Physical work:	Light	Moderate	Heavy	Hours per day	None
Exercise:	Light	Moderate	Heavy	Hours per day	None
Caffeine:	Coffee	Tea	Cola	Cups per day	None

Family medical history:	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			

Immunizations/Vaccinations:(Positive= circle, please include date of the immunization.) Childhood immunizations, Tetanus, Pneumococcal, Meningitis, Hepatitis, Flu, Other:
When was your last: Pap smear? Breast exam? Mammogram? Prostate exam?
Stool for blood?

Prevention:

Do you wear seat belts?	Yes	No	Do you have a donor card?	Yes	No
Do you wear a bike helmets?	Yes	No	Do you have a living will?	Yes	No
Have you engaged in any activity which has put you at risk of getting AIDS?	Yes	No	Method of birth control?		
Have you ever worked with chemicals, paints, asbestos, or other hazardous material?	Yes	No			
Are you in a relationship in which you have been physically hurt (i.e. slapped, kicked, punched, bruised) by your partner?	Yes	No			
You ever feel afraid of your partner?	Yes	No			

Doctor's Care

Associates, L.L.C.

DOCTOR'S CARE ASSOCIATES, L.L.C. PATIENT NAME: DATE:

REVIEW OF SYSTEMS: CIRCLE only the ones that are POSTITIVE for recent or present problems.

(Any POSITIVE answers for a specific system, must also include the NEGATIVE responses for that system, if the ENTIRE system is NEGATIVE,you may CIRCLE the box for ALL NEGATIVE.) Please see attached sample sheet.

KEY: POSITIVE = CIRCLES NEGATIVE = SLASHES (/) (Additional symptoms maybe written in the boxes)

General: weakness, fatigue, fever, malaise, chills, night sweats, lightheadedness. All negative
Skin: nail changes, hair changes, moles, rashes, itching, sores, dryness, baldness, color changes. All negative
Head: headaches, injuries, lose of consciousness, poor concentration. All negative
Eyes: contacts, cataracts, blurred vision, glaucoma, redness, itching, burning, swelling, pain, dryness, tearing. All negative
Ears: difficulty hearing, deafness, ringing, discharge, earache, itching, loss of balance, dizziness, perforated eardrum. All negative
Nose: decreased smell, nosebleeds, nasal discharge, obstruction, postnasal trip, deviated septum, runny nose, nasal congestion. All negative
Mouth; bad breath, mouth ulcers, blisters, bleeding gums, sores, dental problems, pain, loss of taste, dryness. All negative
Throat: sore throat, difficulty swallowing, pain with swallowing, recurrent strep infections. All negative
Neck: pain, masses, enlargement, stiffness, soreness, lumps, thyroid disorder. All negative
Heart: chest pain, murmurs, palpitations, chest pressure, rapid heartbeat, heart disease, hypertension, arrhythmias. All negative
Lungs: wheezing, shortness of breath, asthma, environmental allergies, coughing, shortness of breath with exertion, mucus production,coughing up blood, chest pain with cough, chest congestion. All negative
Gastrointestinal: difficulty with swallowing, pain with swallowing, pain, nausea, vomiting, diarrhea, constipation, black tarry stools,change in bowel function, rectal bleeding, stool incontinence, bloating, heartburn, belching, gas, hemorrhoids. All negative
Genitourinary: difficulty with urination, burning with urination, frequency, blood, pain, urination at night, urgency, incontinence, stones,decreased stream, dribbling, cloudy urine, hesitancy, urethral discharge, bedwetting. All negative
Neurological: seizures, loss of consciousness, paralysis, tremor, weakness, dizziness, numbness, unsteady, slurred speech,loss of memory, decreased concentration, disorientation, difficulty walking. All negative
Musculoskeletal: muscular pain, weakness, leg cramps, joint stiffness, joint pain, join swelling, back pain, injuries, arthritis. All negative
Endocrine: diabetes, thyroid disorder, weight loss, weight gain, hoarseness, heat or cold intolerance, hair loss, hair growth. All negative
Psychological: depression, anxiety, obsessive compulsive disorder, difficulty sleeping, irritability, decreased appetite, poor concentration,racing thoughts, panic attacks, repetitive actions, stress, worrying, feelings of guilt. All negative
Hematological: anemia, easy bruising, oral/nasal bleeding All negative
Gynecological: FDLMP: Contraception: Pregnancies: Menopause: