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NAME:_____**DOB:**_____

What brings you in today? _____

Vital Sign: **Height:** _____ **Weight:** _____ **Blood Pressure:** _____ **Shoe Size:** _____

Surgical/ Injury History:

List the type of surgery and date: _____

List any injuries that required medical attention or hospitalization and the date:

_____

Social History (Circle one for each that apply below)
Are you Pregnant: Yes / No

Tobacco Use: Everyday Smoker / Occasional Smoker / Former Smoker / Never Smoked

Year started smoking: _____ Year Quit: _____

Alcohol Use: How many drinks per week? _____ History of alcoholism? Y/N History of drug use? _____

Medical History (Circle all that apply)

Anemia Arthritis (Osteoarthritis) Arthritis (Rheumatoid) Asthma Blood Disorder Back Pain Cancer Blood Clots COPD Gout Heart Disease Hepatitis (B or C) HIV+/AIDS High Blood Pressure Reflux Kidney Disease Neurological Disorder Seizures Strokes Thyroid Problem Stomach Ulcers

Diabetes – Last Blood Sugar _____ **AIC**_____

Last date seen General Physician: _____ **Last date seen Eye Doctor:** _____

Other: _____

Immunization: (Please write last date received)

Influenza: _____ **Pneumococcal:** _____ **Covid-19:** _____

TURN TO THE BACK PLEASE 

Family History (Circle all that apply)

Alcoholism Asthma Blood Disorder Cancer Diabetes Heart Disease Hepatitis High Blood Pressure Kidney Disease

Neurological Disease Seizures Strokes Thyroid Problem

Foot Issues: _____ Other: _____

Medication List (list all current medication and dosages – including non-prescription/over the counter medication) _____

_____

_____

Pharmacy

What is your preferred pharmacy?

Name _____Phone _____

Address _____

Allergies – Medication / Environmental (Circle all that apply)

☐ No Known Allergies Penicillin Sulfa Tetracycline Codeine Adhesive Tape Latex Iodine/Betadine/Shellfish

Radiographic Dyes Non-Steroidal Anti-inflammatories (Advil,Motrin,Aleve)

_____ _____

Signature of patient, guarantor, or responsible party **Relationship to patient**

_____ _____

Print name of person whose signature appears **Date**

65 Years Old and Over Questionnaire

Do you have a do-not-resuscitate (DNR) care plan? Yes/No

Have you fallen in the past year? Yes/No

I understand the information on this form is essential to determine my medical needs and the provision of treatment. I understand that if any changes occur in my medical history/health, I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and I will not hold any staff member responsible for any errors that I have made in the completion of this form.