

Patient Name: _____

Chart Number _____

DOB: ____/____/____

Adult Initial Visit (p. 1): Please provide the following medical information to the best of your ability:

Date:	Age:	List any ALLERGIES TO MEDICATIONS:	
What problems are you here for today?			
Past Medical History:			
1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain			
	<u>Yes</u>	<u>No</u>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension (high blood press)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease/cholesterol probs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory probs / asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER MEDICAL DIAGNOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):			
3) Please list any current medications (and amounts, times per day);			
<i>(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds):</i>			
Social History:			
	<u>Yes</u>	<u>No</u>	Please list details below:
Do you smoke or chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	List how much: _____
If no, did you use tobacco in past?	<input type="checkbox"/>	<input type="checkbox"/>	For how long?: _____
Do you have pets in your home?	<input type="checkbox"/>	<input type="checkbox"/>	_____
How often do you drink alcohol?			What type?: _____
How often do you drink caffeine?			_____
What is your occupation?			Marital Status? _____
Family History:			
Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:			
If yes, please indicate which relative(s) have the problem			
	<u>Yes</u>	<u>No</u>	
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Reviewed by: _____

ADULT
HX

Adult Initial Visit (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:

2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today

		Yes	No	Current		Yes	No	Current
GENERAL	chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY	environmental allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sneezing fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
NEURO	headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	passing out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	eye pain / pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vision changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ENT	ear pain or itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	sense of smell problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	problem snoring, apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat dryness/itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIR.	cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEME/LYM	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sweating at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDO	feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MSK	joint aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH	depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anxiety or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE SIGN AND DATE: _____

Date: ____/____/____

PLEASE STOP HERE

See Dictated Note

Reviewed by: _____