BOONE COUNTY FAMILY MEDICINE

Patient's Name: _____Birthdate: _____

Today's Date: _____ **Primary Care Provider:** _____

Reason for Visit: _____

Medication Allergies: _____

_____

Preferred Pharmacy: _____

Medications-Name/Dose/How often take:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

(List all additional Medications under Additional Information on next page)

- **Past Medical History** (check all that apply)

Cardiopulmonary: ☐COPD ☐Heart Disease ☐High Blood Pressure ☐Congestive Heart Failure ☐High Cholesterol ☐Pulmonary Embolism ☐Other: _____

Gastrointestinal: ☐Abdominal Aortic Aneurism ☐Colitis ☐GERD ☐Abdominal Pain ☐Diverticulitis ☐Gastrointestinal Hemorrhage ☐Other_____

Genitourinary: ☐Incontinence ☐Kidney Stone ☐Urinary tract infections ☐Kidney Disease ☐Other: _____

Musculoskeletal: ☐Arthritis ☐Musculoskeletal pain ☐Other: _____

Neurological: ☐Multiple Sclerosis ☐Migraines ☐ Fibromyalgia ☐Other: _____

Endocrine: ☐Diabetes type I ☐Diabetes type II ☐Hypothyroidism ☐Hyperthyroidism ☐Obesity ☐Other: _____

Cancer: ☐Type_____ Date: _____

BOONE COUNTY FAMILY MEDICINE

Patient's Name: _____Birthdate: _____

- **Family History:**

	AGE	Diseases	If Deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

- **Smoking Assessment:**

Tobacco Status: ☐Current smoker-Packs/day_____ ☐Former smoker/Date quit: _____
☐Smokeless tobacco user ☐ Never smoked

- **Social History:**

Alcohol Use: ☐None ☐Occasionally ☐Daily ☐Rarely ☐Other _____

Illegal Substance Use:
☐None ☐Marijuana ☐Cocaine/crack ☐Amphetamines ☐Hallucinogens
☐Tranquilizers/sedatives ☐Opiates ☐Pain Killers ☐Club/designer drugs ☐Inhalants
☐Injection drugs ☐Other _____

Marital Status: ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced
Excessive Exposure at Work/home: ☐Fumes ☐Dust ☐Solvents ☐Air-borne Particles ☐Noise
Occupation: _____
Lives independently: ☐Yes ☐No
Assisted Living (current): ☐Yes ☐No
Nursing Home (current): ☐Yes ☐No

- **Surgical History: (Procedure/Date):**

Health Maintenance: ☐Colonoscopy: _____(date) ☐ EGD: _____ (date)
Other Surgeries (please list type & date):

_____
_____
_____
_____
_____

Additional information:

_____
_____
_____
_____
_____

Above information has been entered into patient's medical record ☐ YES ☐ NO

Phys. signature_____ Date_____

BOONE COUNTY FAMILY MEDICINE

Patient's Name: _____Birthdate: _____

General Health:

☐No complaints ☐Appetite Change ☐Excessive Sweating ☐Fatigue ☐Fever
☐Night Sweats ☐Weight Gain ☐Weight Loss ☐Chills ☐Other_____

Eyes:

☐No Complaints ☐Blurred Vision ☐Corrective Lenses ☐Double vision ☐Eye Irritation
☐Eye Pain ☐Spots in Vision ☐Vision Loss ☐Other_____

Ears, Nose, Mouth, Throat:

☐No Complaints ☐Ear pain ☐Hearing loss ☐Ringing in ears ☐Dizziness ☐Facial pain
☐Nasal discharge ☐Nasal obstruction ☐Nosebleeds ☐Postnasal drainage ☐Bleeding gums
☐Dental pain ☐Mouth lesions ☐Hoarseness ☐Sore throat ☐Other _____

Cardiovascular:

☐No Complaints ☐Chest pain ☐Decr. Exercise tolerance ☐Difficulty breathing w/ exercise
☐Shortness of breath while lying down ☐Palpitations ☐Syncope ☐Pain in legs w/ walking
☐Leg ulcers ☐Peripheral edema ☐Other _____

Respiratory:

☐No Complaints ☐Cough ☐Sputum production ☐Blood in Sputum ☐Shortness of breath
☐Sharp pain in chest w/ breathing ☐Wheezing ☐Snoring ☐Apneas ☐Other _____

Gastrointestinal:

☐No Complaints ☐Abdominal pain ☐Bloating ☐Food intolerance ☐Nausea ☐Vomiting
☐Difficulty swallowing ☐Reflux/heartburn ☐Change in bowel habits ☐Constipation
☐Diarrhea ☐Black stools ☐Bloody stools ☐Other _____

Breast:

☐No Complaints ☐Mass ☐Redness ☐Tenderness ☐Swollen Axillary lymph nodes
☐Nipple discharge ☐Skin dimpling ☐Retraction ☐Asymmetry ☐Other _____

Genitourinary:

☐No Complaints ☐Blood in urine ☐Painful urination ☐Incontinence
☐Awaking at night to urinate ☐Urinary Frequency ☐Urinary Urgency ☐Sexual dysfunction
☐Painful intercourse; FEMALES: ☐Painful menses ☐Postmenopausal ☐Vaginal Discharge
☐Irregular menses ☐Heavy menses ☐no menses
☐Other _____

Musculoskeletal:

☐No Complaints ☐Back pain ☐ Joint pain ☐Joint swelling ☐Limited Range of motion
☐Muscle aches ☐Muscle weakness ☐Stiffness ☐Other _____

Integumentary (Skin):

☐No Complaints ☐Hair changes ☐Lesions ☐Pigment changes ☐Itching ☐Rash
☐Other_____

Neurological:

☐No Complaints ☐Abnormal gait ☐Weakness ☐Headaches ☐Incoordination
☐Memory problems ☐Numbness ☐Seizures ☐Slurred speech ☐Tremor
☐Other _____

Endocrine:

☐No Complaints ☐Excessive thirst ☐Excessive hunger/appetite ☐Excessive urination
☐(Female) Abn. menstrual pattern ☐Heat/Cold intolerance ☐Recent weight gain/loss
☐Hot flashes ☐Night sweats
☐Other _____

Hematology:

☐No Complaints ☐Bruising ☐Bleeding tendencies ☐Swollen lymph nodes
☐Recurrent infections ☐Other _____

Allergy/Immune:

☐No Complaints ☐Eczema ☐Seasonal allergies ☐Hives/Rashes
☐Other _____

Psychiatric:

☐No Complaints ☐Anxiety ☐Decreased concentration ☐Irritability
☐Panic attacks ☐Sleep disturbances ☐Sadness/tearfulness ☐Depression
Other_____ _____

Above information has been entered into patient's medical record ☐ YES ☐ NO

Phys. signature_____ date_____