



To help facilitate your initial appointment, please complete the questions below and bring this document with you to your appointment.

Name: _____ Date: _____ Date of Birth: _____

Current Medical Conditions

Medications

Please list all of the medications that you are currently taking. Attach additional pages if needed.

Name of medication	Dosage	Number of times daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you taking any of the following medications? Please check Yes or No

Medication	Yes	No
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen (Advil®) or naproxen (Aleve®)	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin D	<input type="checkbox"/>	<input type="checkbox"/>
Calcium	<input type="checkbox"/>	<input type="checkbox"/>
Multivitamin	<input type="checkbox"/>	<input type="checkbox"/>
Other vitamin or supplement	<input type="checkbox"/>	<input type="checkbox"/>

Name of your previous primary care physician: _____

Allergies/Intolerance

Please list any medications allergies along with reaction (example: penicillin – rash). Attach additional sheets if necessary.

1. _____
2. _____
3. _____

Do you have a latex allergy? Yes No

Medical History

Please list any medical conditions.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please check any other current/past medical conditions you have not already listed above:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> MRSA (staph) infection |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis/osteopenia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sexually transmitted illness |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis |

Please indicate if you have completed any of the following procedures/treatments:

Procedure/ Treatment	Yes	Date Completed
Flu vaccine	<input type="checkbox"/>	_____
Pneumonia vaccine (Pneumovax®)	<input type="checkbox"/>	_____
Tetanus vaccine	<input type="checkbox"/>	_____
Shingles vaccine (Zostavax)	<input type="checkbox"/>	_____
COVID-19 vaccine	<input type="checkbox"/>	_____
Colonoscopy	<input type="checkbox"/>	_____
Prostate cancer screening (men)	<input type="checkbox"/>	_____
Mammography (women)	<input type="checkbox"/>	_____
Bone density test (women)	<input type="checkbox"/>	_____
Pap test / pelvic exam (women)	<input type="checkbox"/>	_____

Past Surgical History

Please list your surgical history.

Type of Surgery	Date of Surgery (Year)	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Obstetrical/Gynecological History

For women, please indicate your obstetrical and gynecological history below.

History of	Number	History of	Yes	No
Pregnancies	_____	HPV	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriages	_____	Abnormal pap	<input type="checkbox"/>	<input type="checkbox"/>
Abortions	_____	Date of last menstrual period	_____	

What is your current form of birth control? Please check all that apply.

- None
 Medication
 Tubal ligation
 Vasectomy
 IUD
 Condom

Family History

	Health History	Living	If deceased, list cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Social History

Occupation: _____

Married Single Divorced Widowed

Do you exercise? Yes No

If yes, how many days per week? _____

Are you sexually active? Yes No

If yes, are your partners? Men Women Both

Have you ever smoked? Yes No

If yes, what? cigarettes pipe cigars e-cigs/vaping chewing tobacco How many years? _____

Do you usually drink over 2 cups of caffeinated beverages per day?

Yes No How many do you drink per day? _____

Do you regularly drink alcohol? Yes No

If yes, please check the answer(s) that best describe your consumption.

Liquor 1 oz/day 2 oz/day 4 oz/day 6+ oz/day

Beer 1 bottle/day 2 bottles/day 3+ bottles/day

Wine 1 glass/day 2 glasses/day 3+ glasses/day