

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

Symptoms

Check (✓) symptoms you currently have or have had in the past year

GENERAL

- Chills, Depression, Dizziness, Fainting, Fever, Forgetfulness, Headache, Loss of Sleep, Loss of weight, Nervousness, Numbness, Sweats

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in: Arms, Back, Feet, Hands, Hips, Legs, Neck, Shoulders

GENITO-URINARY

- Blood in urine, Frequent urination, Lack of bladder control, Painful urination

GASTROINTESTINAL

- Appetite poor, Bloating, Bowel changes, Constipation, Diarrhea, Excessive hunger, Excessive thirst, Gas, Hemorrhoids, Indigestion, Nausea, Rectal bleeding, Stomach Pain, Vomiting, Vomiting blood

CARDIOVASCULAR

- Chest Pain, High Blood Pressure, Irregular heart beat, Low blood pressure, Poor circulation, Rapid heart beat, Swelling of ankles, Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums, Blurred vision, Crossed eyes, Difficulty Swallowing, Double vision, Earache, Ear discharge, Hay fever, Hoarseness, Loss of hearing, Nosebleeds, Persistent cough, Ringing in ears, Sinus problems, Vision - Flashes, Vision - Halos

SKIN

- Bruise easily, Hives, Itching, Change in moles, Rash, Scars, Sore that won't heal

DIALYSIS

- M-W-F, T-Th-S

Date Dialysis Began \_\_\_\_\_

Dialysis Facility Name \_\_\_\_\_

Dialysis Facility Phone \_\_\_\_\_

Nephrologist Name \_\_\_\_\_

Nephrologist Phone \_\_\_\_\_

Cardiologist Name \_\_\_\_\_

Cardiologist Phone \_\_\_\_\_

Conditions

Check (✓) conditions you currently have or have had in the past year

- AIDS, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding Disorders, Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts, Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart Disease, Hepatitis, Hernia, Herpes, High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Pacemaker, Pneumonia, Polio, Prostate Problem, Psychiatric Care, Rheumatic Fever, Scarlet Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsillitis, Tuberculosis, Typhoid Fever, Ulcers, Vaginal Infections, Venereal Disease

Medications

List medications with dose and frequency

Blank lines for listing medications with dose and frequency.

Allergies

Blank lines for listing allergies, including Pharmacy Name and Pharmacy Phone.

# Hospitalizations & Surgeries

Year	Hospital	Reason for Hospitalization and Outcome	Physician

Have you ever had a blood transfusion?  Yes  No  
 If yes, please give approximate dates \_\_\_\_\_

## Pregnancies

Year of Birth	Sex of Birth	Complications if any

## Health Habits

Check (✓) which you use and how much you use

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

## Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substance
	Heavy Lifting		Other

Occupation \_\_\_\_\_

Do you have a living will?  
 Do you have a durable power of attorney for healthcare?

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Reviewed By

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

\_\_\_\_\_  
 Date