Name: _____Age: _____ DOB _____Today's Date: _____

Primary Care Physician: _____

Welcome Back! Please take a few moments to fill out this form completely to help update our records. If something doesn't apply to you, please mark N/A.

What is the major reason for your visit: Annual/Other (Circle):

Please list any allergies you have:

Current Medications: Please list prescription medication/vitamins, along with dosages.

Birth Control Method: **Have you had all 3 Gardasil shots?**

Please list any new medical problems, surgeries, or family history since your last visit:

Total # of pregnancies _____ Total # of living children_____

Social History:

- Do you smoke(Y/N)? How often?
- Drink alcohol(Y/N)? How often?
- Drug use (Y/N)?
- Are you employed (Y/N)? Occupation?
- Are you a victim of domestic violence(Y/N)?
- What do you do for exercise regularly? (Y/N)?
- Who currently lives with you?

Have there been any changes in home life/work life?

When was your last:

Last Menstrual Period: _____Pap smear:_____Flu vaccine:_____

Mammogram: _____Colonoscopy:_____Bone Density Scan_____

Review of Systems (Please let us know if you have problems with any of the following):

CV: chest pain/pressure irregular heart beat swollen legs **REPRODUCTIVE**: irregular menses menopause sexual dysfunction
NEURO: headaches memory problems numbness/tingling **HEM/LYMPH**:bruising/bleeding anemia swollen lymph nodes
ENDO: cold intolerance thyroid problems **SKIN**: itching burning rash
URINARY: frequency pain with urination leaking of urine **CONSTITUTIONAL**: weight loss weight gain fever fatigue
GI: bloody stool nausea/vomiting diarrhea **ENT**: hearing loss congestion sore throat blurred vision
EYES: vision change glasses **MUSCULOSKELETAL**: muscle/joint pain swelling of joints
PSYCH: depression suicide attempt eating disorder **RESP**: shortness of breath chronic cough coughing up blood

Pharmacy name & location:_____Pharmacy telephone #:_____

FOR OFFICE USE ONLY:
Ht: _____Wt: _____ BP: _____Temp:_____