## introductory patient information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Legal Name |  |  | Date |  |
| Preferred Name |  |  | Phone |  |
| DOB |  |  | Age |  |
| Referral Source |  | Primary Care Physician |  |

## Additional Medical Providers

|  |  |  |
| --- | --- | --- |
| Name | Specialty | Location |
|  |  |  |
|  |  |  |
|  |  |  |

# Presenting Problem – why are you here today?

|  |
| --- |
| **In your own words what happened or prompted you to make this appointment? Use the back page if needed.** |
|  |
|  |
| When did it start? How long has it been going on?  |
|  |
|  |
| What does it feel like? What makes it better or worse? |
|  |
|  |
| Did something trigger a change in health?  |
|  |
|  |
| When was the last time you felt well?  |
|  |
|  |
|  |

# Current pain scale 1-10



## Workers Compensation or Motor Vehicle Claims

Is this visit related to workers comp: Yes [ ]  No [ ]

Is this visit related to a Motor Vehicle Accident: Yes [ ]  No [ ]

## Other treatments

|  |  |
| --- | --- |
|  | How often? (Weekly, monthly, occasionally) |
| Acupuncture  |  |
| Chiropractic |  |
| Massage |  |

## Allergies

|  |  |
| --- | --- |
| Name | Reaction |
|  |  |
|  |  |
|  |  |

## nutritional supplements *(vitmains, minerals, herbs)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Dose | Frequency | Start Date | Reason for Use |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|

|  |  |
| --- | --- |
| Please check here and use the back of this form to continue supplement list if needed.  |  |

 |

## current medications

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Dose | Frequency | Start Date | Reason for Use |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Please check here and use the back of this form to continue medication list if needed.  |  |

## prior medication and reason for stopping

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name | Dose | Frequency | Start Date | End Date | Reason for Use and Stopping |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Please check here and use the back of this form to medication list if needed |  |

# Comprehensive Health Background

## Immunization history

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Date(s) |  |  | Date(s) |
| Flu shot – influenza |  |  | **Pneumonia-13** |  |
| Tetanus/diphtheria/pertussis |  |  | **Pneumonia-23** |  |
| Meningococcal |  |  | **HPV** |  |
| Measles/mumps/Rubella |  |  |  **Zoster-Shingles** |  |

## Current medical problems in order of priority

|  |  |  |
| --- | --- | --- |
| Name | Severity (Mild/Moderate/Severe) | Prior treatments |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Please check here and use the back of this form to continue medication list if needed. |  |

## Reproductive history female

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age at menarche (first period |  |  | Date of Last Period |  |
| Have you experience menopause, what age? |  |  | Are your periods regular with normal flow? |  |
| How many times have you been pregnant? |  |  | How many living children do you have? |  |
| How many children born on time? |  |  | How many children born early? |  |
| How many miscarriages? |  |  | How many abortions? |  |
| How many cesareans? |  |  | How many vaginal deliveries? |  |
| How many deliveries required vacuum or forceps? |  |  | How many deliveries were induced with medications? |  |

Have you experienced Any of the following?
Postpartum Depression [ ]  Toxemia [ ]  Gestational Diabetes [ ]  Baby over 8 pounds [ ]

## Reproductive history male

Are both testes descended? Yes [ ]  No[ ]  Do you have or have you ever had a hernia? Yes [ ]  No[ ]

## Family history

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Sister(s) | Brother(s) | Maternal Grandma | Maternal Grandpa | Paternal Grandma | Paternal Grandpa | Aunt(s) | Uncle(s) |
| Age if living |  |  |  |  |  |  |  |  |  |  |
| Age at Death |  |  |  |  |  |  |  |  |  |  |
| Adopted unknown |  |  |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |  |  |
| Blood disease |  |  |  |  |  |  |  |  |  |  |
| CAD-Heart attack |  |  |  |  |  |  |  |  |  |  |
| Cancer-what kind |  |  |  |  |  |  |  |  |  |  |
| Crohn’s disease |  |  |  |  |  |  |  |  |  |  |
| Dementia |  |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |  |
| Diabetes Type 1 |  |  |  |  |  |  |  |  |  |  |
| Diabetes Type 2 |  |  |  |  |  |  |  |  |  |  |
| Heart failure |  |  |  |  |  |  |  |  |  |  |
| High cholesterol |  |  |  |  |  |  |  |  |  |  |
| High blood pressure |  |  |  |  |  |  |  |  |  |  |
| Irritable bowel disease |  |  |  |  |  |  |  |  |  |  |
| Kidney disease |  |  |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |  |  |
| Osteoarthritis |  |  |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |  |
| Substance abuse |  |  |  |  |  |  |  |  |  |  |
| Thyroid disease |  |  |  |  |  |  |  |  |  |  |
| Ulcerative colitis |  |  |  |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |  |  |  |

# Sexual history

Assigned sex at birth: Select one

Female [ ]  Male [ ]  Other [ ]  Decline to answer [ ]

Sexual orientation: Select all that apply

Asexual [ ]  Bisexual [ ]  Gay [ ]  Straight (heterosexual) [ ]

Lesbian [ ]  Pansexual[ ]  Queer[ ]  Questioning/Unsure [ ]

Same-Gender Loving [ ]  Prefer not to disclose [ ]

An identity not listed: please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current gender identity: Select all that apply

Female [ ]  Male [ ]  Gender Queer [ ]  Decline to Answer [ ]

Transgender Female/Transwoman/MTF [ ]  Transgender male/Transman/FTM [ ]

Other: please specify \_\_\_\_\_\_\_\_\_\_\_\_

Preferred pronoun(s): Select all that apply

She/her [ ]  He/him [ ]  They/them [ ]  Name Only [ ]

Other: please specify \_\_\_\_\_\_\_\_\_\_\_\_

## Sexual behavior - Select all that apply

Please describe your sexual activity during the last year:

I was in a monogamous relationship with a man (I had sex with only one man) [ ]

I was in a monogamous relationship with a woman (I had sex with only one woman) [ ]

I had multiple male partners [ ]

I had multiple female partners [ ]

I had both male and female partners [ ]

I did not have any sexual partners [ ]

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Method of birth control if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of STD, Herpes, warts, HPV or other, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary relationships

Single [ ]  Married [ ]  In a civil union [ ]  In a domestic partnership, living together [ ]

Partnered not living together [ ]  Divorced [ ]  Widowed [ ]  In a committed relationship [ ]

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Social history – check box as applicable with amount used

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | None/never | Daily | Weekly | Yearly | Former/quit date |
| Tobacco use |  |  |  |  |  |
| Alcohol use |  |  |  |  |  |
| Marijuana use |  |  |  |  |  |
| Caffeine use |  |  |  |  |  |
|  |  |  |  |  |  |
|  | **Sedentary** | **2x/week** | **Moderate** | **5x/week** | **Vigorous** |
| Exercise activity |  |  |  |  |  |

## Dental procedures

|  |  |  |
| --- | --- | --- |
| Procedure | Date(s)  | Duration or number as applicable |
| Wisdom teeth removal |  |  |
| Other extractions |  |  |
| Braces |  |  |
| Permanent retainer or plates |  |  |
| Removable retainer |  |  |
| Night guard |  |  |
| Implants |  |  |
| Root canal or cavities |  |  |
| Dentures |  |  |

## Surgeries and Procedures

|  |  |  |
| --- | --- | --- |
| What kind, side if applicable | Date | Why was it done |
|  |  |  |
|  |  |  |
|  |  |  |

## Hospitalizations

|  |  |  |
| --- | --- | --- |
| For what | Date(s) | Where |
|  |  |  |
|  |  |  |
|  |  |  |

## Trauma – any major incident including childhood

|  |  |  |
| --- | --- | --- |
| How (MVA, falls) | Date(s) or approximate age | What was injured (bone fractures, organs) |
|  |  |  |
|  |  |  |
|  |  |  |

## General health screening

|  |  |
| --- | --- |
|  | Date and if result abnormal |
| Colonoscopy |  |
| Dental exam |  |
| DEXA scan – bone density |  |
| EKG |  |
| Endoscopy |  |
| Eye exam |  |
| Hemoccult |  |
| Last full physical |  |
| Lipid panel |  |
| Mammogram, normal or abnormal ever |  |
| PAP, normal or abnormal ever |  |
| PSA |  |
| Rectal exam |  |
| Sigmoidoscopy |  |
| Stress test |  |
| Urinalysis |  |

## review of symptoms

**General:** No problems [ ]  Fevers, Night Sweats, Significant Weight Gain, Significant Weight Loss, Exercise Intolerance

**Eyes:** No problems [ ]  Dry Eyes, Vision Change, Irritation

**Ears:** No problems [ ]  Difficulty Hearing, Ear Pain

**Nose:**  No problems [ ]  Frequent Nose Bleeds, Nose Problems, Sinus Problems

**Throat:** No problems [ ]  Sore Throat, Bleeding Gums, Snoring, Dry Mouth, Mouth Ulcers, Oral or Teeth Abnormalities

**Heart:**  No problems [ ]  Chest Pain, Arm Pain on Exertion, Shortness of Breath when Walking, Shortness of Breath when Lying Down, Palpitations, Known Heart Murmur

**Lungs:** No problems [ ]  Cough, Wheezing, Shortness of Breath, Coughing Up Blood, Sleep Apnea, Sputum Production

**Stomach/Bowels:** No problems [ ]  Abdominal Pain, Nausea, Vomiting, Constipation, Abnormal Appetite, Diarrhea, Vomiting Blood, Dyspepsia, GERD, Difficulty Swallowing, Bowel Movement Changes, Rectal Bleeding

**Genitourinary:** No problems [ ]  Incontinence, Difficulty Urinating, Hematuria, Increased Frequency

**Female:** No problems [ ]  Abnormal Bleeding, Flank Pain, Trouble Urinating, Rash, Lesion, Discharge, Vaginal Odor or Itching

**Musculoskeletal:** No problems [ ]  Muscle Aches, Muscle Weakness, Arthralgia/Joint Pain, Back Pain, Swelling in Extremities

**Skin:** No problems [ ]  Abnormal Mole, Jaundice, Rashes, Laceration

**Neurologic:** No problems [ ]  Loss of Consciousness, Weakness, Numbness, Seizure, Dizziness, Migraines,
Headaches, Tremor

**Psychiatric:** No problems [ ]  Depression, Sleep Disturbance, Feeling Safe in Relationship, Alcohol Abuse, Anxiety, Hallucinations, Suicidal Thoughts

**Endocrine:** No problems [ ]  Fatigue, Menstrual Problems, PMDD, Menopausal, Sexual Problems

**Blood/Lymph:** No problems [ ]  Swollen Glands, Bruising, Excessive Bleeding

**Allergic/Immunity:** No problems [ ]  Runny Nose, Sinus Pressure, Itching, Hives, Frequent Sneezing

### All of the above items were reviewed with the patient by the physician and are confirmed as noted above and documented in the medical record.

**Dr. Rosendahl \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**