## introductory patient information

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

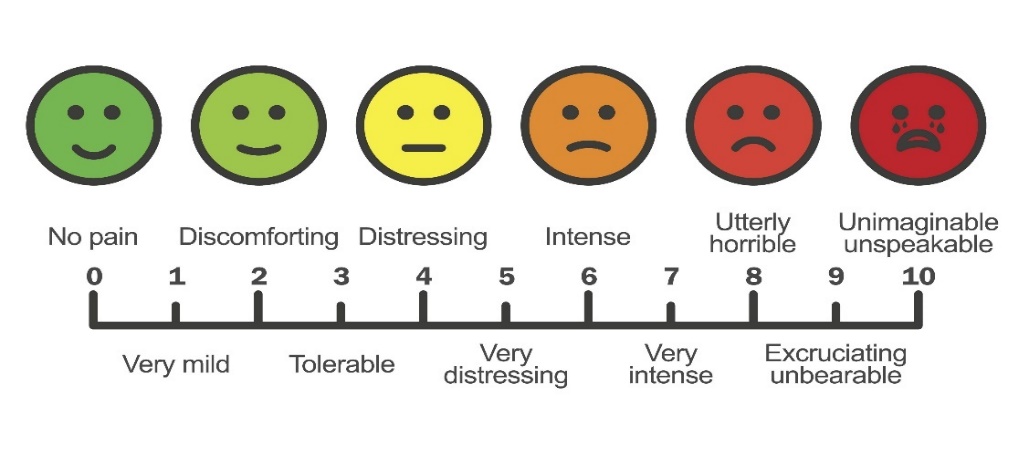
## Additional Medical Providers

|  |  |  |
| --- | --- | --- |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**