## introductory patient information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Legal Name |  | |  | Date |  |
| Preferred Name |  | |  | Phone |  |
| DOB |  | |  | Age |  |
| Referral Source |  | Primary Care Physician |  | | |
| School |  | Grade |  | | |
| Person Filling  out Form |  | Relationship to Patient |  | | |

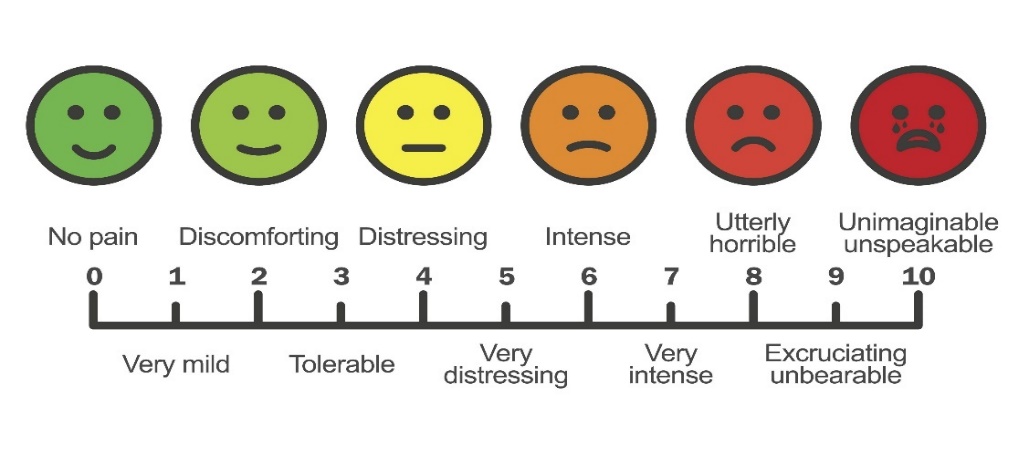
## Additional Medical Providers

|  |  |  |
| --- | --- | --- |
| 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 the patient felt well? |

# Current pain scale 1-10



## Motor Vehicle Claims

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

## 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 |  |
|  |  |  |  |  | |
|  |  |  |  |  | |
|  |  |  |  |  | |
| 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

## Current medical problems in order of priority

|  |  |  |
| --- | --- | --- |
| Name | Severity (Mild/Moderate/Severe) | Prior treatments |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Dental procedures

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

## 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 |  |  |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |  |  |
| 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 |  |  |  |  |  |  |  |  |  |  |

## Surgeries and procedures

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

## Hospitalizations

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

## Trauma – any major incident

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

## General health screening

|  |  |
| --- | --- |
|  | Date and if result abnormal |
| Dental Exam |  |
| Eye Exam |  |
| Last Full Physical |  |

## Perinatal history: Choose those that apply

Pregnancy Complications in mom

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Toxemia |  |  | Illness |  |  |  |  |
| Threat of Miscarriage |  |  | Infection |  |  |  |  |
| Hospitalizations |  |  | Operation |  |  |  |  |

Full-Term  // Premature: # of weeks \_\_\_\_\_\_\_ // Birth Weight/Length \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Labor

Spontaneous  // Induced  // Duration (hours) \_\_\_\_\_\_\_\_

Type of Delivery

Normal  // Breech  // Caesarean  // Forceps  // Vacuum  // Apgar Scores \_\_\_\_\_\_\_\_\_\_

Complications

Cord around neck  // Hemorrhage  // Infant injured during delivery  // Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post delivery period

Jaundice  // Cyanosis (turned blue)  // Incubator  // Infection

Number of days infant was in hospital after delivery, due to infant’s condition: \_\_\_\_\_\_\_

Breast fed for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bottle fed for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infancy: Were any of the following present? Chose all that apply

Colic / Fussy  Reflux / Vomiting  Difficulty Feeding

## coordination & Milestones

|  |  |  |  |
| --- | --- | --- | --- |
| As a toddler and into childhood | More than average  Good | Average | Less than average  Poor |
| Walking |  |  |  |
| Running |  |  |  |
| Athletic Abilities |  |  |  |
| Hand Writing |  |  |  |
| Clumsiness |  |  |  |
| Milestones | Early | Normal | Late |
| Rolled over |  |  |  |
| Sat up |  |  |  |
| Crawled |  |  |  |
| Walked |  |  |  |
| Toilet Trained |  |  |  |

# interests

|  |
| --- |
| **Hobbies and Interests?** Comments? Is there anything we need to know that we haven’t already asked? |

## review of sySTEMS

**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 wILL BE reviewed with the patient by the physician and are confirmed as noted above and documented in the medical record.

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