REGIONAL PRIMARY CARE

Name:____ DOB:_______________ Today's Date:_________________

Reason for Visit:____

MEDICATION LIST

Prescription medications, Supplements, Over the Counter, Substances of Abuse	Dose and Frequency	Date Started	Date Stopped	Name of Provider who prescribes this medicine

ALLERGY LIST

Medication or Allergen	Type of Reaction

REVIEW OF SYSTEMS (Check the box of any symptoms you are currently having.)

GENERAL	Appetite Change / Weight Gain / Weight Loss/ Fever / Chills / Sweats
EARS	Ringing / Hearing Loss / Infection / Drainage / Pain
EYES	Visual Changes / Double Vision / Eye Pain / Eye Discharge
NOSE/THROAT	Nasal Drainage / Sinus Pressure / Nosebleeds / Gum Bleeding / Tongue Soreness / Difficulty Swallowing / Hoarseness
LUNGS	Cough / Shortness of Breath / Wheezing / Coughing Up Blood / Known TB Exposure
HEART	Chest Pain / Skipping Beats / Rapid Heart Rate / Shortness of Breath with Exertion / Swelling in legs / Pain in Legs When Walking
ABDOMEN	Stomach Pain / Nausea / Vomiting / Diarrhea / Constipation / Black Stools / Blood in Stool
URINARY TRACT – MEN	Difficulty Urinating / Dribbling / Trouble Holding Urine / Up at Night to Urinate / Blood in Urine / Discharge From Penis / Erectile Dysfunction
URINARY TRACT – WOMEN	Difficulty Urinating / Trouble Holding Urine / Up at Night to Urinate / Blood in Urine / Abnormal Menstrual Periods / Menopause since :_____________ / Hysterectomy / Pelvic Pain
ENDOCRINE	Thyroid Trouble / Heat or Cold Intolerance / Diabetes / Excessive Thirst, Hunger, or Urination
NEUROLOGIC	Dizziness / Extremity Numbness or Weakness / Headache / Memory Loss / Seizures / Tremors / Loss of Consciousness / Loss of Function of arms or legs / Confusion
EMOTIONAL	Nervousness / Mood Swings / Depression / Anxiety / Difficulty Sleeping
SKIN	Brittle Hair or Nails / Hair Loss / Mole Changes / Rashes / Non-healing Lesions
JOINTS/MUSCLES	Backache / Pain in Joints / Joint Swelling / Pain in Muscles / Weakness / Neck Pain
BLOOD/GLANDS	Easy Bleeding/ Easy Bruising / Swollen Glands / Anemia
IMMUNOLOGIC	Contact Allergy (poison ivy) / Food Allergies / Seasonal Allergies

REGIONAL PRIMARY CARE

Name:____ DOB:________________ Today's Date:__________________

CHRONIC MEDICAL CONDITIONS (Ongoing or Long-Term Problems like high blood pressure, diabetes, etc)

Type of Problem	Approximate date of Onset	Managing Provider (If other)	Ongoing	Resolved

MEDICAL/SURGICAL HISTORY

Problem	Date of Surgery, ER Visit, etc.	Facility / Provider	Problems (if any)

DIAGNOSTIC STUDIES (Indicate any lab tests, x-rays, MRI/CT, Mammogram, etc. that you have had since your last visit here that were ordered by another provider.)

Name of Test	Date of Test	Ordering Provider	Where was Test Performed

FAMILY HISTORY (Check to Indicate Positive History)

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depression									
Colon/Rectal Cancer									
Breast Cancer									
Other Cancer									
Other									

REGIONAL PRIMARY CARE

Name:____ DOB:________________ Today's Date:__________________

SOCIAL HISTORY

Language/Communication Barrier: ☐ No ☐ Yes Explain:
Interpreter or Other Accommodation Provided Today:
Tobacco: ☐Never ☐Current ☐Prior Use Type (check): Cigarettes/ Cigars/ Pipe/ Chewing/ Vapor **Quit Date or Years of Use: ☐2nd Hand Exposure Amount per Day:**
Alcohol: ☐ Never ☐ Occasional ☐ Daily ☐ History of Alcohol Abuse (Please Describe):
Caffeine: ☐ Never ☐ Occasional ☐ Daily
Drug Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use **Please describe History of Abuse:**
☐ Married ☐ Divorced ☐ Widowed ☐ Separated Occupation: **Exercise (Type and Frequency):**
Home Environment: ☐ Private Home ☐ Assisted Living ☐ Other (Describe):

OTHER PROVIDERS OF CARE (Includes Specialists, Chiropractors, Therapists, In-Home Care, etc.)

Provider Name	Type of Care	Date of Last Visit

ACUTE PROBLEMS (New or short-term Problems. Example: Cough, injury, constipation, etc.)

Type of Problem	Date of Onset	Managing Provider (if other)	Ongoing	Resolved

Please do not write below this space.

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PROVIDER USE ONLY

I have reviewed and/or noted all pertinent history and findings indicated above.

____ ________________________________

Provider Signature **Date**