

PATIENT INFORMATION

Full Legal Name

Date of Birth

Today's Date

VITAL SIGNS / RECENT MEASUREMENTS (IF KNOWN)

Height

Weight

Blood Pressure

Pulse

Temperature

CURRENT MEDICATIONS & SUPPLEMENTS

List all current medications, vitamins, and supplements (name, dose, frequency)

HEALTH CONCERNS FOR THIS VISIT

List any specific health concerns or questions you would like to discuss today

PREVENTIVE CARE HISTORY

Last Physical Exam Date

Last Blood Work Date

Last Eye Exam Date

Last Dental Exam Date

Last Colonoscopy (if applicable)

Last Bone Density (if applicable)

IMMUNIZATIONS

Check all vaccines received (enter year if known):

Flu (annual)

COVID-19

Tdap/Td

Pneumococcal

Shingles (Shingrix)

RSV

Hepatitis A

Hepatitis B

HPV

Other vaccines / notes

REVIEW OF SYSTEMS — CHECK ALL THAT APPLY IN THE PAST 3 MONTHS

Constitutional

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Unexplained weight gain | |

Head / Eyes / ENT

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Eye pain/redness |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Nasal congestion |
| <input type="checkbox"/> Sore throat | | |

Cardiovascular

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling in legs |
| <input type="checkbox"/> Shortness of breath w/ exertion | | |

Respiratory

- | | | |
|--|--------------------------------|-----------------------------------|
| <input type="checkbox"/> Shortness of breath at rest | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Coughing blood | | |

Gastrointestinal

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Heartburn/reflux |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Blood in stool | | |

Genitourinary

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Painful urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urinary incontinence | | |

Musculoskeletal

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Back pain | | |

Neurological

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Balance issues | |

Skin

- | | | |
|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Rash | <input type="checkbox"/> New moles/lesions | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Nail changes | | |

Psychiatric

- | | | |
|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Mood swings | | |

Endocrine

Heat/cold intolerance

Excessive thirst

Excessive hunger

Hot flashes

LIFESTYLE & SOCIAL HISTORY

Tobacco: Never Former Current

Alcohol: None Social (< 7/wk) Moderate (7-14/wk) Heavy (>14/wk)

Exercise frequency: Sedentary 1-2x/wk 3-4x/wk 5+ x/wk

Diet quality: Poor Fair Good Excellent

Current stressors / life changes

GOALS FOR THIS VISIT

What are your primary health goals for the coming year?

PATIENT ACKNOWLEDGMENT

I certify that the information provided is accurate and complete to the best of my knowledge.

Patient / Guardian Signature

Date