PATIENT INFORMATION

Name:			Date:	
Age:	Date of Birth:	Height:	Weight:	Sex: M ☐ F ☐
Allergies to Medicine/Other:				
Reason for visit:				
Referred by:				
Are you current on your immunizations?				
Do you need assistance with ambulation?				
Do you have a history of falls?				

☐ Patient/Caregiver unable to provide History

MEDICATIONS

List all medications you are taking, including vitamins, herbal and over the counter drugs

Name of Medication	Start Date	Stop Date	Dose	Frequency

Pharmacy Name:_____ Phone:_____

PAST MEDICAL HISTORY

If you ever had any problems in the following areas please check box

☐	Bladder Infections	☐	Circulation	☐	Seizures	☐	Hepatitis
☐	Kidney	☐	Diabetes	☐	Chronic Pain	☐	HIV
☐	Arthritis	☐	Emphysema	☐	Thyroid	☐	Digestive
☐	High Blood Pressure	☐	Hearing Difficulty	☐	Cancer	☐	Blood Clots
☐	Stroke	☐	Implants	☐	Asthma	☐	Bleeding
☐	Heart Disease	☐	Tuberculosis	☐	Mental Illness	☐	Liver
☐	Cholesterol	☐	Ulcers	☐	Bad Teeth	☐	Other

PREVIOUS SURGICAL PROCEDURES

Please List

FAMILY HISTORY

If your relative has ever had any of the following problems please check box

	Father	Mother	Brother	Sister	Uncle	Aunt	Grandfather	Grandmother
Arthritis								
Asthma								
Bleeding								
Cancer								
Diabetes								
Heart								
Lung								
Mental								
Other								
Stroke								
Thyroid								

SOCIAL HISTORY

Marital Status:	( ) Married	( ) Single	( ) Divorced	( ) Widowed	( ) Other
Occupation:			Number of Living Children:	
Highest Level of Education:	( ) College	( ) High School	( ) GED	( ) Other
Do you have any special religious or cultural needs?				
Smoking Status:	( ) Current	( ) Former	( ) Never	( ) Exposure to secondhand smoke
Alcohol Use:	( ) Current	( ) Former	( ) Occasionally	( ) Never
Do you feel safe at home?				
Do you want to discuss abuse?				

CURRENT SYMPTOMS AND COMPLAINTS

Yes	No	Constitutional:
○	○	Fatigue
○	○	Fever
○	○	Chills
○	○	Night Sweats
○	○	Marked Weight Change
○	○	Loss of Appetite

OTHER:_____

Yes	No	Eyes:
○	○	Double or Blurred Vision
○	○	Excessive Tearing
○	○	Dry Eyes
○	○	Sensitivity to Light
○	○	Eye Pain

OTHER:_____

Yes	No	Ears/Nose/Mouth/Throat:
○	○	Hearing Loss
○	○	Ear Pain
○	○	Post Nasal Drip
○	○	Loss of Taste
○	○	Loss of Smell
○	○	Nose Bleeds
○	○	Dental Problems
○	○	Bleeding Gums
○	○	Sore Throat
○	○	Hoarseness
○	○	Difficulty clearing ears
○	○	Painful/Swollen Lymph Glands

OTHER:_____

Yes	No	
Genitourinary:		
☐	☐	Decreased Force of Stream
☐	☐	Painful Urination
☐	☐	Frequency
☐	☐	Blood in Urine
☐	☐	Urgency
☐	☐	Incontinence

OTHER:_____

Musculoskeletal:		
☐	☐	Backache
☐	☐	Muscle Pain
☐	☐	Muscle Wasting
☐	☐	Muscle Weakness
☐	☐	Joint Swelling
☐	☐	Contractures

OTHER:_____

Integumentary:		
☐	☐	Change in Hair, Skin, Nails
☐	☐	Skin Dryness
☐	☐	Skin Lumps/Lesions
☐	☐	Itching
☐	☐	Skin Rash
☐	☐	Sun Sensitivity
☐	☐	Hair Loss
☐	☐	Callus/Corns
☐	☐	Prone to Skin Tears

OTHER:_____

Neurologic:		
☐	☐	Abnormal Gait
☐	☐	Room Spinning/Dizziness
☐	☐	Numbness/Loss of Sensation (Feet)
☐	☐	Tingling
☐	☐	Tremors
☐	☐	Weakness
☐	☐	Headaches
☐	☐	Paralysis
☐	☐	Fainting

OTHER:_____

Respiratory:		
☐	☐	Cough
☐	☐	Spitting up Blood
☐	☐	Shortness of Breath
☐	☐	Wheezing
☐	☐	Oxygen Use

OTHER:_____

Hematologic / Lymphatic:		
☐	☐	Bruise Easily
☐	☐	Bleeding Tendency
☐	☐	Swollen/Painful Glands

OTHER:_____

Yes	No	
Cardiovascular (Central / Peripheral):		
☐	☐	Chest Pain
☐	☐	Heart Palpitations
☐	☐	Heavy Sweating
☐	☐	Difficulty Breathing on Exertion
☐	☐	Swelling in legs
☐	☐	Leg Pain when Walking
☐	☐	Difficulty breathing when lying down

OTHER:_____

Gastrointestinal:		
☐	☐	Bowel Incontinence
☐	☐	Change in Bowel Habits
☐	☐	Abdominal Pain
☐	☐	Difficulty Swallowing
☐	☐	Indigestion
☐	☐	Yellow Skin
☐	☐	Nausea/Vomiting/Diarrhea
☐	☐	Blood in Stools
☐	☐	Constipation
☐	☐	Loss of Appetite
☐	☐	Hemorrhoids
☐	☐	Acid Reflux

OTHER:_____

Psychiatric:		
☐	☐	Anxiety
☐	☐	Claustrophobia
☐	☐	Sleep Problems
☐	☐	Suicidal
☐	☐	Memory Loss
☐	☐	Nervous / Tension

OTHER:_____

Endocrine:		
☐	☐	Cold Intolerance
☐	☐	Heat Intolerance
☐	☐	Excessive Thirst
☐	☐	Excessive Hunger
☐	☐	Excessive Urination

OTHER:_____

Allergic / Immunologic:		
☐	☐	Hives
☐	☐	Rhinitis
☐	☐	Hay Fever

OTHER:_____

ADVANCE DIRECTIVE AND INSTRUCTIONS:

☐ Advance Directive: ☐ Yes or ☐ No

☐ Advance Directive Materials Provided

☐ DO NOT RESUSCITATE

☐ Living Will

☐ Copy of Living Will Provided to Facility