Coastal Healthcare

Name: _____ Date of Birth: _____ Todays Date: _____

Why are we seeing you today? _____
____Right ____ Left ____ Both How long has this problem been present? _____

Is this a result of an injury? ____ Yes ____ No Date of Injury: _____ _____

____Work Injury ____Auto Accident ____ Sports Injury Other:_____

Have you had any of the following for this problem? ____X-Rays ____ MRI ____ CT Scan ____ Bone Scan ____ EMG

____Physical Therapy ____ Injections ____ Other: _____

SURGICAL HISTORY

Procedure	Surgery Date	Notes

FAMILY HISTORY Please be specific if it is on the Maternal or Paternal side.

Relation	Problem

Relation	Problems

MEDICATIONS If not enough room, please list on back.

Pharmacy: _____

Medication/Dosage	Directions
Allergies Drug/Allergen	Reaction

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Allergies Drug/Allergen	Reaction

Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY (only mark if yes)

	Yes	Notes		Yes	Notes
ADHD			Heart Attack/MI (angina)		
Abdominal Pain			Heart Disease		
Abnormal Weight Loss			Heart Murmur/Valve Disorder		
Affective Disorders			Hemorrhoids		
Alcoholism			Hepatitis (Acute or Chronic)		
Allergies			Hernia(s)		
Anemia			High Cholesterol		
Anorexia			Hypertension		
Anxiety Disorder			Hyperthyroidism		
Aortic Aneurysm			Hypothyroidism		
Appendicitis			Incontinence: Fecal		
Appetite, poor			Incontinence: Urinary		
Arrhythmia			Indigestion		
Arthritis			Kidney Disease		
Asthma/Breathing Problems			Leg/Foot Ulcers		
a-fib			Liver Disease		
atrial flutter			MRSA		
Bladder or Kidney Problems			Measles		
Bleeding Disorder			Migraine Headaches		
Bloating			Miscarriage		
Blood Diseases			Mononucleosis		
Bowel changes			Mouth sores		
Breast Mass/Cyst			Multiple Sclerosis		
Broken Bones			Mumps		
Bronchitis			Muscle/Joint/Bone Problem		
Bulimia			Nasal Trauma		
CVA/ /Stroke			Nausea Alone		
Cancer			Nausea/Vomiting		
Carotid Disease			Organ Transplant		
Cataracts			Osteopenia		
Chemical/Drug Dependency			Osteoporosis		
Chickenpox			Pacemaker		
COPD			Peptic Ulcers		
Chronic Pain			Peripheral Vascular Problem		
Constipation			Pneumonia		
Coronary Artery Disease			Polio		
Deep Vein Thrombophlebitis			Poliomyelitis		
Depression			Post-Menopausal		
Developmental or Behavioral Disorders			Prostate Problems		
Diabetes			Psychiatric Care		
Dialysis			Pulmonary Embolism		
Diarrhea			Rectal Bleeding		
Difficulty swallowing			Reflux Disease		
Digestive Problems			Rheumatic Fever		

Name: _____ Date of Birth: _____

Diverticulitis			**Scarlet Fever**		
Ear or Hearing Problems			**Seizures or Convulsions**		
Ectopic Pregnancy			**Serious/Traumatic Injuries**		
Emotional Problems			**Sexually Transmitted Disease**		
Emphysema			**Skin Cancer/Problems**		
Epilepsy			**Sleep Apnea (snoring)**		
Fibromyalgia			**Suicide Attempt**		
Gastrointestinal Disease			**shortness of breath**		
Genitourinary Disease			**Tonsillitis**		
GERD/Acid Reflux			**Tuberculosis**		
German Measles			**Typhoid Fever**		
Glaucoma			**Ulcers**		
Goiter			**Urinary Tract Infection**		
Gonorrhea			**Vaginal Infections**		
Gout			**Vision or Eye Problems**		
HIV Positive			**Vomiting blood**		
Headaches or Dizziness					

SOCIAL HISTORY

Occupation						**Notes**	
Education						**Notes**	
Able to Care for self?	Yes		No			**Notes**	
Alcohol intake	None	Occ	Mod	Heavy		**Yrs of use:**	
Special Diet (eg: vegan)						**Notes**	
Exercise level	None	Occ	Mod	Heavy		**Notes**	
Caffeine intake	None	Occ	Mod	Heavy		**Notes**	
DNR in place	Yes	No				**Notes**	
Live alone or with others						**Notes**	
Illicit drugs						**Yrs of use:**	
Stress level	Low	Med	High			**Notes**	
Sporting Activities						**Notes**	
Sexually active?	Yes		No			**Notes**	
Protective sex?	Yes		No			**Notes**	
Past History of Abuse	Yes		No			**Notes**	
Current Abuse	Yes		No			**Notes**	
Type of Abuse	Verbal		Physical	Emotional		**Notes**	
Smoking Status or chewing tobacco	Never	Former	Current Daily	Current Sporadic		**Yrs of use**	How much:

Date of Last Flu Shot: _____ **Date of Last Pneumonia Vaccine: _____**

Colon Cancer Screening: **Date Screened _____**

Screen Type: ☐ **Colonoscopy** ☐ **Flexible Sigmoidoscopy** ☐ **Fecal Occult Blood Testi**

Name: _____ DOB: _____

REVIEW OF SYSTEMS

Please check if you are currently having or have had a history of the following:

CONSTITUTIONAL

____ Excess Weight Loss
____ Excess Weight Gain
____ Fever
____ Exercise Intolerance
____ Night Sweats

ENT and EYES

____ Sore Throat
____ Snoring
____ Sinus Problems
____ Hearing Loss
____ Ear Pain
____ Nose Bleeding
____ Vision Changes
____ Dry Eyes

CARDIOVASCULAR

____ Chest Pain
____ Arm Pain w/exertion
____ Shortness of breath w/walking
____ Shortness of breath w/lying down
____ Palpitations
____ Heart Murmur

RESPIRATORY

____ Cough
____ Wheezing
____ Shortness of Breath
____ Coughing up Blood

GASTROINTESTINAL

____ Change in Appetite
____ Heartburn
____ Nausea
____ Vomiting
____ Constipation
____ Diarrhea
____ Blood in Stool
____ Abdominal Pain
____ Ulcers

GENITOURINARY

____ Incontinence
____ Blood in Urine
____ Frequency
____ Difficulty Urinating

MUSCULOSKELETAL

____ Swelling in Extremities
____ Back Pain
____ Joint Pain
____ Muscle Weakness
____ Muscle Aches

SKIN

____ Rashes
____ Abnormal Moles
____ Itching
____ Dry Skin
____ Jaundice

NEUROLOGICAL

____ Fainting
____ Muscle Weakness
____ Numbness
____ Headaches
____ Stroke
____ Dizziness
____ Seizures

PSYCHIATRIC

____ Depression
____ Sleep Disturbance
____ Feel Unsafe
____ Alcohol Abuse
____ Anxiety

ENDOCRINE

____ Fatigue

HEMATOLOGIC

____ Bruise Easily
____ Swollen Glands
____ History of Blood Clots

ALLERGIC

____ Runny Nose
____ Sinus Pressure
____ Itching
____ Hives
____ Frequent Sneezing

OTHER: (please list)

____ Steroid Use
____ Asthma
____ Heart Attack
____ High Blood Pressure
____ Thyroid Disease
____ Anemia

_____

_____

_____

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