ARIZONA

Patient Name: _____

Date _____ **DOB:** _____ **Gender: M___/ F___**

Allergies or intolerance to medication **[ ] yes** **[ ] no**

List Allergies to medication	Reaction you had to them.

Advance Directive: Living will__, Power of Attorney__, Resuscitate__, DNR/DNI (Do Not Resuscitate) __

Please list the medications Currently Taken, their dosage, and how many times per day you take them:

Please check conditions, which you have had in the past:

CVS
- __Rheumatic Fever
- __High Cholesterol
- __Congestive Heart Failure
- __Heart Attack
- __High Blood Pressure
- __Angina
- __Heart Murmur
- __Heart Valve Disease
- __Blood Clots in veins
- __Blocked Arteries in Legs

Lymphatic/Hematologic
- __Diabetes Mellitus
- __Overactive Thyroid
- __Underactive Thyroid
- __Anemia
- __Thyroid Goiter
- __Blood Transfusion

Skin/Breast
- __Acne
- __Eczema/Psoriasis
- __Fibrocystic Breast disease
- __Abnormal Mammogram
- __Rashes
- __Hives
- __Skin Cancer

Respiratory
- __Sleep Apnea
- __Frequent Bronchitis
- __Emphysema
- __Asthma
- __Clots in lungs
- __Tuberculosis

Musculoskeletal/Extremities
- __Rheumatoid Arthritis
- __Osteoarthritis
- __Joint Pain
- __Gout
- __Osteoporosis
- __Fibromyalgia
- __Neck Pain (hern.disc)
- __Back Pain (hern.disc)

HEENT
- __Glaucoma
- __Hearing loss
- __Frequent Ear Infections
- __Ringing in Ears
- __Seasonal allergies
- __Frequent Sinus Infections

Neurologic/Psychiatric
- __Seizure
- __TIA
- __Stroke
- __Numbness
- __Weakness
- __Memory Loss
- __Migraine Headaches
- __Depression
- __Anxiety
- __Panic Attacks
- __Suicide Attempt
- __Sexual Abuse
- __Mental Illness
- __Dizziness
- __Vertigo
- __Peripheral Nerve Disease
- __Insomnia

General
- __Abnormal Weight Loss
- __Abnormal Weight Gain
- __Cancer of any kind

_____

_____

_____

GI/GU
- __Acid reflux
- __Stomach Ulcers
- __Blood in Stool
- __Hepatitis
- __Diarrhea
- __Constipation
- __Hemorrhoids
- __Abdominal Pain
- __Colon Polyps
- __Urinary Frequency
- __Bladder Infections
- __Prostate Disease
- __Urinary Incontinence
- __Kidney stones
- __Kidney Failure
- __Ulcerative Colitis
- __Cohn's Disease
- __Diverticulitis
- __Diverticulitis
- __Irritable Bowel Disease
- __Cirrhosis of Live
- __Liver Failure
- __Pancreatitis
- __Endometriosis
- __Abnormal Pap smear
- __Sex Transmitted disease
- __HIV infection

Other medical problems _____

#'s of Pregnancy: _____ Live Births _____ Miscarriages _____ Abortions _____

Please indicate any surgeries or Procedures you have had and the <u>year</u> you had them:

- __Angioplasty _____
- __Carotid Artery _____
- __Other Vascular _____
- __Coronary Bypass _____
- __Chest/Lung _____
- __Tonsillectomy _____
- __Neurosurgery _____
- __Trauma Related _____
- __Back/neck _____
- __Hip _____
- __Knee _____
- __Carpal Tunnel _____
- __Sinus _____
- __Ear _____
- __Stomach _____
- __Inguinal Hernia _____
- __Colonoscopy _____
- __Gallbladder _____
- __Appendectomy _____
- __Prostate _____
- __Bladder _____
- __Tubal Ligation _____
- __C-Section _____
- __Hysterectomy _____
- __Ovary Removed _____
- __Breast _____
- __Thyroid _____
- __Other _____

List all Physicians and Specialist you are currently seeing: _____

_____

If <u>WINTER</u> Visitor, PRIMARY CARE DOCTOR at home town: _____

_____

Up to date with all Vaccines: [ ] Yes [ ] No

Please indicate <u>year</u> when you last had any of the following preventative tests or services:

__ Cardiac Angiogram _____ __ Pneumonia 23 Vaccine _____ __ Last Menstrual Period _____
__ Stress Test _____ __ Tetanus Vaccine _____ __ Other _____
__ EKG _____ __ Hepatitis Vaccine _____ __ Colonoscopy _____
__ Chest X-Ray _____ __ Bone Density Test _____ __ Cologuard _____
__ Echocardiogram _____ __ PSA Blood Test _____ __ Mammo/Breast Exam _____
__ Flu Vaccine _____ __ TB TEST _____ __ PAP Smear _____
__ Pneumonia 13 Vaccine _____ __ Colon Cancer Stool Test _____

Family History

<u>Age</u> ***<u>Significant Health Problems</u>***		***<u>Significant Health Problems</u>***	
Father: _____ [ ] Alive [ ] Dead	__ Hypertension __ Any Cancer __ Diabetes __ Heart Disease __ None (circle any that apply)	**Siblings:** _____ __ Hypertension __ Any Cancer __ Diabetes __ Heart Disease __ None (circle any that apply)	**Grandparents:** _____ __ Hypertension __ Any Cancer __ Diabetes __ Heart Disease __ None (circle any that apply)
Mother: _____ [ ] Alive [ ] Dead	__ Hypertension __ Any Cancer __ Diabetes __ Heart Disease __ None	**Children:** _____ __ Hypertension __ Any Cancer __ Diabetes __ Heart Disease __ None	**Other family history:**

Social History

Tobacco	*Do You Use Tobacco?* [ ] Yes [ ] No *Are you a former smoker?* Yes [ ] No [ ] Year quit: _____			
	__ Cigarettes – pks./days? _____	__ Chew - # a Day? _____	__ Pipe - # a Day? _____	__ Cigar - # a Day? _____
Alcohol	*Do you Drink Alcohol?* [ ] Yes [ ] No			
	If Yes, What kind: __ Beer __ Wine __ Hard Liquor *How often?* _____ *How much?* _____			
Drugs	*Do you use recreational or street drugs?* [ ] No [ ] Yes			
	Have you ever given yourself street Drugs with needle? [ ] No [ ] Yes			
Marital Statues	__ Married __ Single __ Separate __ Divorce __ Widowed			
Occupation	__ Retired __ Other (Specify): _____			
Exercise	__ Sedentary	__ Mild Exercise	__ Occasional Exercise	__ Regular vigorous
Caffeine	__ None __ Coffee __ Cola __ Tea __ Energy Drinks		How often?	

Patient Signature _____ **Date** _____