

Welcome To Our Office!

Which provider are you seeing today?

- Dr. Kenny Dr. Drewitz Dr. Mills Dr. Noland Dr. Tharalson Dr. Randolph Traci Kelly N.P.

Appointment time: _____ **Check in time:** _____

Today's Date: _____ Referring Physician: _____

Patients Name: _____ Birthdate: _____ Age: _____

Gender: Male Female Language preference: _____

Reason for today's visit: _____

HEALTH HISTORY

Allergies

None Iodine Sulfa Eggs Other: _____

Aspirin Penicillin Versed Latex

Previous Illnesses

None Colon polyps Gall bladder problems High cholesterol Pancreatitis

Anemia Crohn's disease Glaucoma H. pylori Liver disease

Asthma Diabetes Heart disease HIV/AIDS Ulcer/gastritis

Barrett's Esophagus Diverticulosis/itis Hepatitis/type Irritable bowel Arthritis

Cancer/Type Emphysema/COPD Hiatal hernia Jaundice Other: _____

Colitis Endocarditis High blood pressure Kidney disease Other: _____

Previous Operations or Treatments

None Colon surgery EGD (within last 5 years) Pacemaker/heart valve Thyroid surgery

Appendix surgery Colonoscopy (within last 5 years) Gall bladder surgery Sigmoidoscopy (within last 5 years) Other: _____

Blood transfusion When: _____ Ovary/uterus surgery Stomach surgery Other: _____

<u>Social History Marital Status</u>	<u>Number of Children</u>	<u>Social History Exercise</u>
<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+ <input type="checkbox"/> None	<input type="checkbox"/> None <input type="checkbox"/> Walk <input type="checkbox"/> Jog <input type="checkbox"/> Bike <input type="checkbox"/> Swim <input type="checkbox"/> Golf <input type="checkbox"/> Aerobics <input type="checkbox"/> Weights

<u>Social History - Alcohol</u>		<u>Social History – Tobacco/Drugs</u>	
<input type="checkbox"/> Never	<input type="checkbox"/> More than 2 Days/week	<input type="checkbox"/> I use tobacco products	<input type="checkbox"/> Never used tobacco products
<input type="checkbox"/> Rarely	<input type="checkbox"/> Less than 2 days/week	<input type="checkbox"/> I quit using tobacco products	<input type="checkbox"/> Have used street drugs/when
<input type="checkbox"/> Daily	<input type="checkbox"/> I quit using alcohol		

<u>Social History - Occupation</u>	<u>Social History - Hobbies</u>
Patient Occupation _____	<input type="checkbox"/> Veteran Hobbies _____

REVIEW OF SYSTEMS

<u>Gastrointestinal</u>				
<input type="checkbox"/> None	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Flatus/gas	<input type="checkbox"/> Nervous bowel	<input type="checkbox"/> Jaundice (yellow eyes)
<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Nausea	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Painful Swallowing	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Feel full quickly	<input type="checkbox"/> Thin stools	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Food sticks in esophagus	<input type="checkbox"/> Abdominal cramps	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Black stools	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Regurgitation	<input type="checkbox"/> Bloating	<input type="checkbox"/> Loss of control BM	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Belching	<input type="checkbox"/> Bowel change	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other: _____

<u>Urinary</u>	<u>Skin</u>
<input type="checkbox"/> None	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Burning with urination	<input type="checkbox"/> None
<input type="checkbox"/> Frequency of urination	<input type="checkbox"/> Rash
<input type="checkbox"/> Loss of bladder control	<input type="checkbox"/> Tattoos
	<input type="checkbox"/> Bruising
	<input type="checkbox"/> Body piercing
	<input type="checkbox"/> Suspicious lesions
	<input type="checkbox"/> Itching
	<input type="checkbox"/> Skin Cancer
	<input type="checkbox"/> Acne
	<input type="checkbox"/> Other: _____

<u>Cardiovascular</u>		
<input type="checkbox"/> None	<input type="checkbox"/> Sleep on stack of pillows	<input type="checkbox"/> Leg swelling
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Oxygen use	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Poor exercise tolerance	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Other: _____

<u>Neurological</u>	<u>Endocrine</u>
<input type="checkbox"/> None	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Headache
<input type="checkbox"/> Depression	<input type="checkbox"/> Seizures
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> None
	<input type="checkbox"/> Weight gain more than 10lbs
	<input type="checkbox"/> Excessive thirst
	<input type="checkbox"/> Cold/heat tolerance
	<input type="checkbox"/> Menopause
	<input type="checkbox"/> Impotent
	<input type="checkbox"/> Other: _____

<u>Constitutional</u>		<u>Eyes, Ears, Nose and Throat</u>	
<input type="checkbox"/> None <input type="checkbox"/> Fever/chills <input type="checkbox"/> Sweats <input type="checkbox"/> Weight loss more than 10lbs.	<input type="checkbox"/> Decreased appetite <input type="checkbox"/> Excessive fatigue <input type="checkbox"/> Other: _____	<input type="checkbox"/> None <input type="checkbox"/> Eye Pain <input type="checkbox"/> Eye redness/itching <input type="checkbox"/> Hoarseness <input type="checkbox"/> Vision change <input type="checkbox"/> Hearing loss	<input type="checkbox"/> Nosebleeds <input type="checkbox"/> Ear pain/ringing <input type="checkbox"/> Inability to smell things <input type="checkbox"/> Dentures/Partials <input type="checkbox"/> Neck lumps <input type="checkbox"/> Other: _____

<u>Musculoskeletal</u>		<u>Respiratory</u>	
<input type="checkbox"/> None <input type="checkbox"/> Muscle aches <input type="checkbox"/> Joint stiffness/soreness	<input type="checkbox"/> Recent Injury <input type="checkbox"/> Other: _____	<input type="checkbox"/> None <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing/Asthma <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Other: _____

<u>Medications</u>			
MEDICATION	DOSE	MEDICATION	DOSE

<u>Family History</u>						
	Father	Mother	Children	Brother(s)	Sister(s)	Grandparents
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____	_____	_____	_____	_____	_____