In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Preferred Pharmacy: #1_____ #2_____

Describe the two primary reasons for your visit:

	Reason 1	**Reason 2**
Explanation		
Date first occurred		
Frequency		
What makes conditions improve?		
What makes conditions worse?		
Do you think this problem will resolve itself?	**□ Yes □ No**	**□ Yes □ No**
Previous treatments? (Was treatment helpful?)		
Practitioner who provided treatment	**Name:** **Phone:**	**Name:** **Phone:**

SUBJECTIVE HEALTH ASSESSMENT

How would you describe your overall health on a scale from 1 – 10 (10 being "perfect" health")? _____

If above answer is less than 6, why do you give this rating and what do YOU think we can or should do about it?_____

MEDICAL PROBLEMS/DIAGNOSES (present): Please check if you **have** any of the following **□ None**

	No		**Yes**	**No**	
		High blood pressure			Kidney stones
		Diabetes, year diagnosed:			Rectal bleeding
		Peptic ulcers			Diverticulosis
		Birth defects, describe:			Thyroid problems
		Chest pain/tightness			Lung problems/asthma
		History of heart murmur			Shortness of breath
		Heart disease			Hepatitis
		Stroke			Depression/Anxiety/Bipolar/Mood Disorder
		Cancer, type:			High Cholesterol
		Yellow jaundice			Chronic Pain

		Gallstones			Other (list below):

OPERATIONS/PROCEDURES: List names and dates of **all** operations you have had □ **None**

Year	Name of Operation	Year	Name of Operation

MEDICATIONS: Please list ALL prescription, non-prescription, herbal drugs and supplements □ **Check if None**

Drug	Dosage	Drug	Dosage

ALLERGIES: Please list type and reaction □ **No known allergies**

Drug	Reaction	Drug	Reaction

FAMILY HISTORY □ **Check if family history is UNKNOWN**

If your family has a history of any of these conditions, please do the following:

a. Write 'F' for father, 'M' for mother, 'S' for sibling or 'E' for extended family within the parentheses

b. Mother: □Living □Deceased, cause/age: _____

c. Father: □Living □Deceased, cause/age: _____

( ) High cholesterol ( ) Heart Attack (age:_____) ( ) Kidney problems

( ) High blood pressure ( ) Diabetes ( ) Prostate Cancer

( ) Stroke ( ) Depression ( ) Colon Cancer

( ) Obesity ( ) Psychiatric issues ( ) Breast Cancer

( ) Alcoholism ( ) Seizure disorder ( ) Other (describe):_____

SOCIAL HISTORY

Y N	
□ □	Do you smoke now? Packs per day? Age started?
□ □	Do you drink alcohol now? How much/often?
□ □	Did you drink alcohol excessively in the past?
□ □	Do you currently use street drugs? What?
□ □	Are you sexually active? How many partners in past year?
□ □	Have you used street drugs in the past? What?
□ □	Are you married?
□ □	Employed? Type of work:
□ □	Do you have children? How many?

INJURIES: Please list all significant injuries and dates

Date	Injury	Treatment	Ongoing symptoms

FEMALES ONLY

Y N	
□ □	Are you pregnant or think you might be?
□ □	Ever had an abnormal pap smear?
□ □	Ever had an abnormal mammogram?
□ □	Do you have an IUD?
□ □	Are you on Birth Control? (please list under *medications* above)
□ □	Do you have an OB/GYN that you see regularly; Name:

OTHER DOCTORS/HEALTH PROVIDERS: Please list those within past 2 years □ **Check if None in past 2 years**

Name	Specialty	Reason

REVIEW OF SYSTEMS: Are you now experiencing or have you recently had any of the following?

Y N		Y N	
	1. Constitutional		**7. Genito-Urinary**
□ □	Recent fever	□ □	Blood in urine
□ □	Recent weight loss	□ □	Painful urination
	2. Eyes		**8. Musculoskeletal**
□ □	Glaucoma	□ □	Frequent fractures or sprains
□ □	Recent changes in vision	□ □	History of arthritis
	3. Ears, Nose, Mouth, Throat		**9. Integumentary**
□ □	Frequent ear infections	□ □	Recent changes in skin
□ □	Frequent sore throats		**10. Neurological**
□ □	Frequent sinus infections	□ □	History of frequent headaches
	4. Cardiovascular	□ □	Seizures or convulsions
□ □	Chest pains or discomfort in chest		**11. Psychiatric**
□ □	Shortness of breath	□ □	Treatment for psychiatric problems
	5. Respiratory (*circle those that apply*)	□ □	Treatment for drug or alcohol dependency
□ □	Asthma, bronchitis, pneumonia, emphysema, TB, coughing blood		**12. Endocrine**
	6. Gastrointestinal	□ □	Decreased energy
□ □	Frequent indigestion or heartburn	□ □	Dizziness
□ □	Vomiting		**13. Hematologic/Lymphatic**
□ □	Passing bloody or black stools	□ □	Easy bruising or bleeding
			14. Allergic/Immunologic
		□ □	Severe allergic reactions to:
		□ □	Hay fever

The above information is true and accurate.

_____

Patient signature (parent, if patient is a minor) Date

PREVENTATIVE HISTORY: Please list the **LAST** time you had the procedure. *Please check* "Decline" if you DO NOT wish to have this procedure even if recommended ***Females only**

Procedure	Date	Result	N/A	Never	Interested	Decline
Colonoscopy			□	□	□	□
Flu Shot			□	□	□	□
Bone Density Scan			□	□	□	□
Pneumonia vaccine			□	□	□	□
Mammogram*			□	□	□	□
Pap Smear*			□	□	□	□

Are Your Childhood Immunizations up-to-date? □ Yes □ No □ N/A

Who suggested that you seek care at **Enclave Family Healthcare**, PLC?
□ Self □ Referring medical professional □ Family □ Neighbor/friend □ Other _____