

Patient Name: _____

PCP: _____

Date: ___/___/___

Adult Initial Visit Form (p. 1): Please provide the following medical information to the best of your ability:

Age: _____	DOB: ___/___/___	List any ALLERGIES TO MEDICATIONS:
What problems are you here for today?		

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No		Yes	No		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergy problems/therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease/cholesterol probs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma / lung problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach or Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Other Medical Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

2) Please list any operations (and dates) you have ever had (including tonsils & adenoids):

3) Please list any current medications on the enclosed green Patient Medication List

Social History:

Yes	No	Please list details below:	
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	How much and for how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	If no, did you smoke previously?	How much and for how long? _____ When did you quit? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you chew tobacco?	How much and for how long? _____
		How often do you drink alcohol?	_____ What type? _____
		Describe your hobbies	_____
		What is your occupation?	_____ Marital status? _____

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses: If yes, please indicate which relative(s) have the problem

	Yes	No		Yes	No		
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma or lung problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy / sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	Anesthesia problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Other health problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

See attached dictation

Reviewed by: _____

Patient Name: _____

Date: ___/___/___

Adult Initial Visit Form (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:								
1) Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms:								
2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for your visit today								
		Yes	No	Current		Yes	No	Current
GENERAL	fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight loss or gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGY	environmental allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sneezing fits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	food allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEURO	headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	passing out / seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES	eye pain / pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vision changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
ENT	ear pain or itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ear noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	swelling neck or face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	ear pressure / fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	dizziness, vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent "sinus infec's"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	discolored nasal dischg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	recurrent throat infec's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	snoring with pauses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	throat dryness/itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RESPIR.	cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	wake short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bowel irregularity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GU	frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEMALE:	Pregnant at present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Post-menopausal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEME/LYM	swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sweating at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDO	feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel cooler than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	increased thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	increased urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MSK	joint aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SKIN	rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	skin or hair changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCH	depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anxiety or panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> See attached dictation								
Reviewed by: _____								

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Environment Review: Please complete details of all the sections that apply to you

	Yes	No
Do you live in the city?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in the country?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live on a farm?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trees and/or lawn?	<input type="checkbox"/>	<input type="checkbox"/>
Do you live in a house:	<input type="checkbox"/>	<input type="checkbox"/>
Age of house, years lived there	_____ / _____	
Do you live in an apartment/condo?	<input type="checkbox"/>	<input type="checkbox"/>
Age and years lived there	_____ / _____	
Do you live in a mobile home?	<input type="checkbox"/>	<input type="checkbox"/>
Age and years lived there	_____ / _____	
Do you have a basement/crawl space	<input type="checkbox"/>	<input type="checkbox"/>
Is it wet or dry?	_____	
Do you have carpeting?	<input type="checkbox"/>	<input type="checkbox"/>
Age and amount?	_____	
Have you remodeled lately?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have indoor plants?	<input type="checkbox"/>	<input type="checkbox"/>
Are there smokers in your home, apartment, or condo?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a hepa filter?	<input type="checkbox"/>	<input type="checkbox"/>
What type of heating system?	_____	
What type of cooling system?	_____	

	Yes	No
Do you work outdoors?	<input type="checkbox"/>	<input type="checkbox"/>
Do you work indoors?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have increased symptoms at school or work?	<input type="checkbox"/>	<input type="checkbox"/>
List any school or work related allergy/sinus symptoms	_____	
Do you use a mask when you clean, mow, or sweep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have feather pillows?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have down comforters?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use pillow/mattress covers?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have frequent exposure to:		(if yes, circle:)
Dog	<input type="checkbox"/>	<input type="checkbox"/> Inside or Outside
Cat	<input type="checkbox"/>	<input type="checkbox"/> Inside or Outside
Bird	<input type="checkbox"/>	<input type="checkbox"/> Inside or Outside
Rodents	<input type="checkbox"/>	<input type="checkbox"/> Inside or Outside
Livestock	<input type="checkbox"/>	<input type="checkbox"/>
Other (list)	<input type="checkbox"/>	<input type="checkbox"/> Inside or Outside

PLEASE STOP HERE

See attached dictation

Reviewed by: _____