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Direction of Feed

Patient History

Please answer every question

STAFF: *Responses in boxed bubbles and handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

Pharmacy: _____ **Email address:** _____

Referring MD: _____ **PCP** (Primary Care Physician)**:** _____

Reason for visit: _____

PAIN

Location of pain: _____

Context (what caused it)**:** _____

Severity of pain on a scale of 1-10 (1 = no pain & 10 = worst pain imaginable)**:** _____

Quality of pain (e.g., aching, burning)**:** _____

Duration (when did it start?)**:** _____

Timing (e.g., constant, comes and goes)**:** _____

Modifying factors (what makes it better or worse?)**:** _____

Associated signs / symptoms: _____

Is this a chronic condition? yes ⬭ no ⬭

INJURY

Was there an injury? yes ⬭ no ⬭

If so, was this an auto injury? yes ⬭ no ⬭

If so, was this a worker's comp injury? yes ⬭ no ⬭

What was the injury? _____

When did occur? _____

Where did it happen? _____

How did it happen? _____

MEDICATIONS

Please list all medications you are currently taking.

Include **PRESCRIPTION** and **OVER THE COUNTER** medications. (e.g., aspirin, blood thinners, vitamins, supplements, herbs, etc.)

⬭ **I Take No Medications**

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

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ALLERGIES

Please list all known allergies:

◯ **I Have No Known Drug Allergies**

Substance	Reaction

Substance	Reaction

DEMOGRAPHIC DATA

The following questions are required by CMS for Meaningful Use:

Gender:	male ◯	female ◯					
Ethnicity:	Hispanic ◯	Non-Hispanic ◯	other ◯				
Race:	African American ◯	Asian ◯	Hispanic ◯				
	American Indian ◯	Caucasian ◯	other ◯	prefer not to answer ◯			
Preferred language:	English ◯	Spanish ◯	other ◯				

SOCIAL HISTORY

Occupation: employed ◯ retired ◯ unemployed ◯ **Job:**_____

Marital status: single ◯ married ◯ divorced ◯ widowed ◯

Pregnancies: none / not applicable ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7+ ◯

TOBACCO USE

What is your smoking status? current (every day) ◯ current (some days) ◯ previous ◯ never ◯

Type(s) of tobacco used: chewing / smokeless ◯ cigarettes ◯ cigars ◯ pipe ◯

How many packs per day do you (or did you) **smoke?** less than 1 ◯ 1-2 ◯ more than 2 ◯

How many years have you (or did you) **smoke?** less than 5 ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 25 ◯ 30 ◯ 35 ◯ 40+ ◯

How many years ago did you quit (if applicable)**?** less than 1 ◯ 1-2 ◯ 3-5 ◯ 6-10 ◯ 11-20 ◯ 21+ ◯

Have you been counseled to quit smoking (if applicable)**?** yes ◯ no ◯

Are you exposed to passive (second hand) **smoke?** yes ◯ no ◯

Alcohol use: none ◯ social ◯ daily ◯

Illicit drug use: none ◯ current ◯ previous ◯

PAST MEDICAL HISTORY

Please indicate if <u>YOU</u> have a history of any of the following:

◯ **I Have No Medical Problems**

◯ Stroke or TIA
◯ Heart Trouble
◯ High Blood Pressure
◯ High Cholesterol
◯ Diabetes
◯ Cancer
◯ Seizures
◯ Kidney Disease / Stones
◯ Blood Clots
◯ Bleeding Disorder(s)
◯ Anemia
◯ Alcoholism
◯ Asthma / Lung Disease
◯ COPD
◯ Rheumatoid Disease
◯ Osteoporosis
◯ Depression
◯ Phlebitis
◯ Stomach Ulcer(s)
◯ Hepatitis
◯ Tuberculosis
◯ Thyroid Trouble
◯ Irritable Bowel (IBS)
◯ Gout
◯ Fibromyalgia
◯ HIV
◯ Other (please specify):
_____

PAST SURGICAL HISTORY

Please indicate if <u>YOU</u> have had any of the following:

◯ **I Have Had No Surgeries**
◯ Brain
◯ Spine (neck / back)
◯ Heart
◯ Lung(s)
◯ Abdomen
◯ Kidney(s)
◯ Breast
◯ Uterus / Ovary(ies)
◯ Testicle(s)
◯ Upper Extremity
◯ Lower Extremity
◯ Pacemaker
◯ Eye(s)
◯ Other (please specify):
_____

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PREVENTATIVE HEALTH MAINTENANCE

COLORECTAL CANCER SCREENING

- ◯ **I have had a colonoscopy.** Date:_____
- ◯ **I have NOT had a colonoscopy.** ◯ date not known

FLU VACCINE

- ◯ **I have had a flu vaccine.** Date:_____
- ◯ **I have NOT had a flu vaccine.** ◯ date not known

PNEUMOVAX

- ◯ **I have had a pneumovax vaccine.** Date:_____
- ◯ **I have NOT had a pneumovax vaccine.** ◯ date not known

BREAST CANCER SCREENING

- ◯ **I have had a mammogram.** Date:_____
- ◯ **I have NOT had a mammogram.** ◯ date not known
- ◯ **Does not apply.**

PAP SMEAR

- ◯ **I have had a pap smear.** Date:_____
- ◯ **I have NOT had a pap smear.** ◯ date not known
- ◯ **Does not apply.**

Would you like an electronic copy of your medical record or do you prefer we contact you via postal mail?

electronic ◯ postal mail ◯

FAMILY MEDICAL HISTORY

Please indicate if YOUR FAMILY has a history of the following:

◯ **Family History Unknown** ◯ **Adopted** ◯ **No Significant Family History**

Please indicate which family member(s) have had these illnesses.	Mother	Father	Grandparents	Sibling(s) (Brother or Sister)
High Blood Pressure	◯	◯	◯	◯
Stroke	◯	◯	◯	◯
Kidney Disease	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯
Cancer(s)	◯	◯	◯	◯
Bleeding Disorder(s)	◯	◯	◯	◯
Alcoholism	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯

Please mark all symptoms you are CURRENTLY experiencing.

Mark all that apply. If no symptoms, please mark "NONE."

GENERAL		fever / chills ◯	frequent illnesses ◯	**NONE** ◯
SKIN		rash ◯	pale skin ◯	**NONE** ◯
HEENT (Head, Eyes, Ears, Nose, Throat)		hearing loss ◯	glasses / contacts ◯ nose bleeds ◯	**NONE** ◯
NECK		stiffness ◯	headache ◯	**NONE** ◯
RESPIRATORY		difficulty breathing ◯	cough ◯	**NONE** ◯
CARDIOVASCULAR	chest pain ◯	swelling of extremities ◯	irregular heartbeat ◯	**NONE** ◯
GASTROINTESTINAL		bloody stool ◯ constipation ◯	nausea ◯ vomiting ◯	**NONE** ◯
GENITOURINARY		frequent urination ◯	hard / painful urination ◯	**NONE** ◯
MUSCULOSKELETAL	calf cramps ◯	back pain ◯	muscle weakness ◯	**NONE** ◯
NEUROLOGICAL		fainting ◯	numbness or tingling ◯	**NONE** ◯
PSYCHIATRIC		anxiety ◯	depression ◯	**NONE** ◯
ENDOCRINE		night sweats ◯	weight change ◯	**NONE** ◯
HEMATOLOGY	abnormal bleeding ◯	easy bruising ◯	blood clots ◯	**NONE** ◯