Padder Health Services

Patient Name: _____ **Date:** _____

♥Current Medications and Dosage:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

♥Personal Medical History: (include approximate year of diagnosis)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

♥Allergies to medication and description of reaction:

1. _____
2. _____
3. _____
4. _____

♥Personal Surgical History:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

♥Hospitalizations within the last year: *(list month, year, and reason for admission)*

1. _____
2. _____
3. _____
4. _____

♥Family History:

♥Health Issues of Relatives:

Father:	□ Living □ Deceased	Age: _____	_____
Mother:	□ Living □ Deceased	Age: _____	_____
Brothers:	□ Living □ Deceased	Age: _____	_____
	□ Living □ Deceased	Age: _____	_____
Sisters:	□ Living □ Deceased	Age: _____	_____
	□ Living □ Deceased	Age: _____	_____
Sons:	□ Living □ Deceased	Age: _____	_____
	□ Living □ Deceased	Age: _____	_____
Daughters:	□ Living □ Deceased	Age: _____	_____
	□ Living □ Deceased	Age: _____	_____

TURN OVER →

♥Social History:

Tobacco Use? □ Current Smoker □ Former Smoker □ Nonsmoker

If current smoker:

- **How often?** □ Every day □ Some days, but not everyday
- **How many cigarettes a day?** □ 5 or less □ 6-10 □ 11-20 □ 21-30 □ 31 or more
- **How soon after waking up do you smoke?** □ Within 5 min □ 6-30 min □ 31-60 min □ after 60 min
- **Are you interested in quitting?** □ Ready to quit □ Thinking about quitting □ Not ready to quit

Alcohol Use? □ Never □ Monthly or less □ 2-4 times/month □ 2-3 times/week □ +4 times/week

- **How many drinks on a typical day?** □ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more
- **How often did you have six or more drinks on one occasion in the past year?**
  □ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Caffeine intake (daily): □ None □ 1-2 cups □ 2-3 cups □ 3-4 cups □ 4-5 cups □ +5 cups

Marital Status? □ Single □ Married □ Divorced □ Separated □ Widowed

List members living in household: Spouse _____ Children _____ others _____

Occupation (current, previous, or retired): _____

♥Review of Symptoms: *(Please check current positives)*

Cardiology: □ Chest pain □ Shortness of breath (SOB) □ SOB during night □ SOB lying flat
□ Palpitations □ Lightheadedness □ Passing out □ Leg swelling
□ Pain in calves while walking

Constitutional: □ Fever □ Chills □ Fatigue □ Change in appetite □ Weight loss
□ Weight gain

ENT: □ Cold symptoms □ Nose bleeds □ Ringing in ears □ Snoring

Respiratory: □ Chest congestion □ Cough □ Wheezing □ Coughing up blood

Endocrine: □ Increased thirst □ Increased urination □ Cold intolerance □ Heat intolerance

Hematology/Lymphatic: □ Easy bruising □ Bleeding □ Anemia

Gastroenterology: □ Nausea □ Vomiting □ Heartburn □ Dysphagia (Difficulty swallowing)
□ Abdominal pain □ Blood in Stool

Musculoskeletal: □ Muscle pain □ Joint pain □ Leg Cramps

Neurology: □ Headaches □ Seizures □ Dizziness □ Gait abnormality

Psychology: □ High Stress Level □ Depression □ Sleep Disturbances □ Anxiety

Urology: □ Painful or difficult urination □ Blood in urine □ Frequent urination during night