Patient Name:______________________ Account No.______________ DOB:___/___/___

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

Date:	Age:	List any ALLERGIES TO MEDICATIONS:
Do you have any current medical problems 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 (Circle: type I/type II)	☐	☐		Stomach or Intestinal problems	☐	☐	
Hypertension (high blood press)	☐	☐		Allergy problems/therapy	☐	☐	
Thyroid problems	☐	☐		Kidney problems	☐	☐	
Heart Disease/cholesterol probs	☐	☐		Neurological problems	☐	☐	
Respiratory problems	☐	☐		Cancer	☐	☐	
Bleeding disorder	☐	☐		Other Medical Diagnosis	☐	☐	

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

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3) Please list any current medications (and amounts, times per day):

(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC meds including sinus/allergy/weight loss meds):

Social History:	Yes	No	Please list details below:	
Do you use tobacco?	☐	☐	List type and how much:	
If no, did you use it previously?	☐	☐	List type and how much:	When did you quit?
Do you drink alcohol?	☐	☐	List type and how much:	
Do you use recreational drugs?	☐	☐	List type and how much:	

What is your occupation?______________________

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	
Heart problems/murmurs	☐	☐	
Allergy	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
Bleeding disorder	☐	☐	
Anesthesia problems	☐	☐	

☐ See attached dictation | Reviewed by:

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Date____/____/____

Patient Name:____ Account No.____________________ DOB:____/____/____

Initial Preventive Medicine 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	chills	☐	☐	☐	weight loss or gain	☐	☐	☐
	fatigue	☐	☐	☐	daytime sleepiness	☐	☐	☐
ALLERGY	environmental allergy	☐	☐	☐	sneezing fits	☐	☐	☐
NEURO	headache	☐	☐	☐	weakness	☐	☐	☐
	passing out	☐	☐	☐	numbness, tingling	☐	☐	☐
EYES	eye pain/pressure	☐	☐	☐	vision changes	☐	☐	☐
	watery or itchy eyes	☐	☐	☐				
ENT	hearing loss	☐	☐	☐	ear noises	☐	☐	☐
	dizziness	☐	☐	☐	lightheadedness	☐	☐	☐
	nasal congestion	☐	☐	☐	sinus pressure or pain	☐	☐	☐
	hoarseness	☐	☐	☐	problem snoring, apnea	☐	☐	☐
	throat clearing	☐	☐	☐	throat pain	☐	☐	☐
RESPIR	cough	☐	☐	☐	coughing blood	☐	☐	☐
	wheezing	☐	☐	☐	shortness of breath	☐	☐	☐
CARDIAC	chest pain	☐	☐	☐	palpitations	☐	☐	☐
	wake short of breath	☐	☐	☐	ankle swelling	☐	☐	☐
GI	difficulty swallowing	☐	☐	☐	heartburn	☐	☐	☐
	abdominal pain	☐	☐	☐	nausea/vomiting	☐	☐	☐
	bowel irregularity	☐	☐	☐	rectal bleeding	☐	☐	☐
GU	frequent urination	☐	☐	☐	painful urination	☐	☐	☐
	blood in urine	☐	☐	☐	prostate problems	☐	☐	☐
HEME/LYM	swollen glands	☐	☐	☐	sweating at night	☐	☐	☐
	bleeding problems	☐	☐	☐	easy bruising	☐	☐	☐
ENDO	feel warmer than others	☐	☐	☐	feel cooler than others	☐	☐	☐
MSK	joint aches	☐	☐	☐	muscle aches	☐	☐	☐
SKIN	rash	☐	☐	☐	hives	☐	☐	☐
	itching	☐	☐	☐	skin or hair changes	☐	☐	☐
PSYCH	depression	☐	☐	☐	anxiety or panic	☐	☐	☐

Practical E/M
Initial Preventive Medicine

PLEASE STOP HERE ☐ See attached dictation

Reviewed by:

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