Today's Date: ____________________

MEDICAL HISTORY

Do you, or have you ever had any of the following? PLEASE CHECK **ONLY** IF IT HAS BEEN DIAGNOSED BY A DOCTOR. ☐ NONE

☐ Acid Reflux
☐ ADHD
☐ AIDS/HIV
☐ Anemia
☐ Anorexia
☐ Anxiety
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Arthritis
☐ Asthma
☐ Autism/Asperger's
☐ Bleeding Disorder
☐ Bulimia
☐ Cancer/Malignancy
☐ Cerebral Palsy
☐ Chemical Dependency
☐ Chicken Pox
☐ Convulsions
☐ Depression
☐ Diabetes
☐ Dizziness/Fainting
☐ Epilepsy/Seizures
☐ Frequent Ear Infections
☐ Frequent Headaches
☐ Hearing Problems
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Problems
☐ Mitral Valve Prolapse
☐ Mononucleosis
☐ Pacemaker
☐ Psychiatric Treatment
☐ Radiation/Chemotherapy
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease

☐ Other: ____

Are you allergic to, or have you ever had a reaction to ANY o the following? ☐ NONE

☐ Aspirin
☐ Anesthetic-local
☐ Barbiturates
☐ Codeine
☐ Dairy
☐ Latex
☐ Metal Sensitivity
☐ Nitrous Oxide Sedation
☐ Sleeping Pills
☐ Sulfa Drugs
☐ Penicillin/Other antibiotics
☐ Other: ______________________________

Please list **ALL** the medications you are currently taking (if possible, include dosage). ☐ NONE

1.__________________ 2. __________________
3. __________________ 4. __________________
5. __________________ 6. __________________
7.__________________ 8. __________________

Please list any surgeries you have had **AND** the approximate date.

1.__________________ 2. __________________
3. __________________ 4. __________________
5. __________________ 6. __________________

Women **ONLY**

Date of last menstrual cycle: ____________
Date of last pap smear: ____________
Date of last mammogram: ____________
Number of pregnancies: ____________

Do you have regular cycles? ☐ YES ☐ NO
Are you currently pregnant? ☐ YES ☐ NO
Have you ever been pregnant? ☐ YES ☐ NO
Any preterm pregnancies? ☐ YES ☐ NO

Men **ONLY**

Year of last prostate exam: ____________

Patient Name: ________________________ Patient DOB: ______________

Today's Date: ____________________

REVIEW OF SYSTEMS				
Circle the items you currently have significant problems with				
GENERAL				
Recent weight changes	Increased thirst	Increased urination	Night sweats	
Hot flashers	Always hot/cold	Rashes or skin problems	Significant fatigue	
Chronic pain problems				
BREAST				
Lumps/tenderness	Do you do monthly self-breast exams?	☐ Yes	☐ No	
Discharge from nipple	Month/year of last mammogram_________________/ ____________			
EAR NOSE THROAT				
Glaucoma	Blurred vision	Double vision	Use glasses/contacts	Hearing loss
Brief loss of vision	Teeth/gum problems	Use dentures	History of radiation to head or neck	
CARDIOPULMONARY				
Shortness of breath with activity	Dizziness	Chest pains	Daily phlegm production	
Difficulty breathing while lying down	Leg cramps	Wheezing	Waking up with shortness of breath	
Daily cough	Ankle swelling			
GASTROINTESTINAL				
Change of appetite	Abdominal pain	Blood in stool/black stool	Difficulty swallowing	
Diarrhea/constipation	Nausea/vomiting	Heartburn	Indigestion from fatty foods	
NEUROPSYCHIATRIC				
Frequent headaches	Disabling headaches	Difficulty sleeping	Tremors	
Frequent anxiety attack	Disabling anxiety attacks	Memory loss	Passing out	
Often feel sad or depressed	Treated for past emotional psychological problems?	☐ Yes	☐ No	
MUSCULOSKELETAL & SKIN				
Frequent back pain	Frequent neck pain	Muscle pain	Leg cramps at night	
Joint problems	Use a brace or splint	Moles that have changed color or size		
GENITOURINARY				
Urinary tact infections	Sores in the genital area	Difficulty urinating	Blood in urine	
History of bladder stones	History of kidney stones	Urination more than once a night		
Method of birth control	History of 4 or more sexual partners	Intercourse before 18		
Have your ever been treated for an STD?	☐ Yes	☐ No		
If yes, what kind? ____				
GENITOURINARY (MEN)				
Lumps in testicles	Lumps in scrotum			
Do you do self-testicular exams?	☐ Yes	☐ No		
GENITOURINARY (WOMEN)				
Date of last pap smear: ______________	Date of last period: _____________	Age period started: ________		
Length of menstrual period (in days): ________	Are your periods regular	☐ Yes	☐ No	
Number of pregnancies: _____	Number of children: ________	Are you sexually active?	☐ Yes	☐ No
Vaginal discharge	Vaginal itching	History of abnormal pap		
Any treatment for abnormal pap?	☐ Yes	☐ No		

****If there is anything we have not asked, feel free to use the "notes" section to let us know****

Patient Name: ____________________________________ Patient DOB: _____________________

Today's Date: ____________________

FAMILY HISTORY FORM							PROVIDER COMMENTS
	Father	Mother	Brother	Sister	Grandparent	Other	
Diabetes							
Glaucoma							
Cancer							
Heart Attack							
Angina							
Stroke							
High Blood pressure							
High Cholesterol							
Alcoholism							
Drug Abuse							
Depression							
Mental Illness							
Suicide							
Other Health Problems							

SOCIAL HISTORY

Spouse's Name:	Spouse's Occupation
Ages of Children:	# of people in household:
Your Occupation:	Place Employed:
Level of Education:	Hobbies:

1. Recent significant changes in your life? ☐Yes ☐No
2. Financial hardships? ☐ Yes ☐ No
3. Any special stresses in your life? ☐ Yes ☐ No

I am **NOT** happy with the following:

- ☐ Myself
- ☐ My partner
- ☐ My health
- ☐ My work
- ☐ My life

Because violence is so common, I've begun to ask all my patients about it

Have you ever been in an abusive relationship?	☐Yes	☐No
Does your partner ever hit you or hurt you?	☐Yes	☐No
Has your partner ever forced you to have sex?	☐Yes	☐No
Are you ever frightened of your partner?	☐Yes	☐No
Has anyone ever hit you or hurt you in the past?	☐Yes	☐ No

ORGAN DONATION

Do you want to be an organ donor? ☐Yes ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive or living will? ☐Yes ☐ No

Patient Name: ____________________________________ Patient DOB: ____________________

Today's Date: ____________________

List the amount of each beverage that you consume per WEEK:				
Coffee/Tea:	Soda:	Liquor:	Beer:	Wine:

Drugs and alcohol can affect your health and the medications you take. Please answer the following:		
1. In the last 12 months, have you not remembered things that happened when you drank?	☐ Yes	☐ No
2. In the last 12 months, have you not remembered things that happened when you used drugs?	☐ Yes	☐ No
3. In the last year, have you drunk more than you mean to?	☐ Yes	☐ No
4. In the last year, have you used drugs more than you meant to?	☐ Yes	☐ No
5. Have you felt you wanted or needed to cut down on your drinking use in the last year?	☐ Yes	☐ No
6. Have you felt you wanted or needed to cut down on your drug use in the last year?	☐ Yes	☐ No
7. In the last year have you drunk or used non-prescription drugs to deal with your feelings, stress or frustration?	☐ Yes	☐ No
8. Because of your drinking or drug use, did anything happen in the last year that you wished didn't happen?	☐ Yes	☐ No

CURRENT HEALTH PRACTICES			
1. Do you exercise regularly?		☐ Yes	☐ No
If yes, what type of exercise and how often:			
2. How many meals do you eat per day?			
3. How many snacks do you eat per day?			
4. Do you consume dairy daily?		☐ Yes	☐ No
5. How many times do you eat out per week?			
6. List any nutrition or diet concerns you would like help with:			
7. If you are on a special diet, please explain:			
8. Are you happy with your weight?		☐ Yes	☐ No
9. Do you have regular dental check-ups?		☐ Yes	☐ No
10. How often do you brush a day?	Floss?		
11. Do you wear your seatbelt?	☐ Always	☐ Sometimes	☐ Never
12. Do you ride any of the following vehicles? ☐ Motorcycle ☐ Bicycle ☐ Ski/snowboard ☐ Skateboard If yes, do you use a helmet?		☐ Yes	☐ No
13. Have you been exposed to toxic substances, such as asbestos, DES, chemicals or radiation? If yes, explain: ____________________		☐ Yes	☐ No
14. Do you have a smoke detector in your home? If yes, when is the last time it was checked? ____________________		☐ Yes	☐ No

NOTES

Patient Name: ____________________ Patient DOB: ____________________

Today's Date: ____________________

SOCIAL HISTORY continued

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐Widow/Widower

Education: ☐None ☐Some High School ☐ GED ☐High School Grad ☐Technical School ☐ Some College ☐College Graduate

1. Tobacco Use: ☐Current smoker ☐ Former Smoker ☐ Never Smoked
   How many cigarettes do/did you smoke per day? ___________
   How old were you when you started? _____________
   How old were you when you stopped? ____________

2. **Alcohol Use:** ☐Current drinker ☐Former drinker ☐Never drank
   What do you drink? ☐Beer ☐Wine ☐Liquor
   How much AND how often do you drink (i.e. one glass everyday)? _________________
   How old were you when you started drinking? ____________________
   When was the last time you had a drink? _______________
   Former drinker: When did you stop drinking? _______________

3. **Drug Use:** ☐Currently drug user ☐ Former drug user ☐ Never used
   How old were you when you started using drugs? ____________
   What is your drug of choice? ______________
   Name the drug(s) that you currently use. ___________________________
   Name the drugs that you have tried and the length of time that you used the drug(s)?
   ____
   When was the last time you used? ____________________
   Former drug use? Clean date: ____________________________

CONSENT FOR TREATMENT

PLEASE READ CAREFULLY

I, _____________________________, hereby voluntarily consent to my treatment at Strawbridge Health, LLC and
(print name)
authorize treatments such as vaccinations, examinations and diagnostic procedures including, but not limited to the use of radiographic and laboratory studies as ordered by my attending provider. In addition, I authorize Strawbridge Health to furnish information to insurance carriers and my primary care doctor concerning my illness and treatments. I understand that I am responsible for any amount not covered by insurance. I have read this consent and am fully aware of its contents. The acknowledgement that assurances or promises have been given to me, the patient concerning the results, which may be obtained by such treatment(s) is hereby affirmed by the signature below.

____ (Signature)

___________________________________ (Date)

Patient Name: ____________________________________

Patient DOB: _____________________