



Date _____

Full Name _____ Birthdate _____ Age _____

Address _____ Phone (contact or cell) (_____) _____

Reason for Visit or Recheck: _____

If Recheck, Please note changes only

How Long? _____ If an injury: Did the injury occur at work? YES/NO Date of injury _____

Current symptoms: Please check or circle. (ROS)

General

___ Fevers/sweats

___ Fatigue

Eyes

___ Change in vision

___ Redness ___ Discharge

Ears/Nose/Throat/Mouth

___ Hearing loss ___ Ear pain

___ Sore throat ___ Voice changes

___ Congestion ___ Allergies

Cardiovascular

___ Hypertension ___ Palpitations

___ Chest discomfort ___ Heart Problems

Respiratory

___ Shortness of breath ___ Wheezing

___ Cough ___ Asthma ___ COPD/Emphysema

Gastrointestinal

___ Pain in abdomen

___ Heartburn/Reflux ___ Diarrhea

___ Nausea ___ Vomiting

___ Blood or change in bowel movement

Musculoskeletal/Extremities

___ Muscle pain ___ Joint pain

___ Recent back pain

___ Swelling ___ Arthritis

Skin

___ Rash ___ Itching

Neurological

___ Headaches

___ Numbness ___ Weakness

___ Loss of Consciousness

___ Dizziness

Psychiatric

___ Anxiety/stress ___ Depression

Genitourinary

___ Frequent or Painful urination

___ Pelvic Pain ___ Discharge

Gynecological (Women)

___ Irregular menstrual periods

___ Menopausal

___ Pregnant

_____ Last Menstrual Period

Medications: Prescription and non-prescription medicines None _____

Allergies & Medication Reactions: None _____

Past Medical & Surgical History: None _____

___ Heart Disease	___ High cholesterol	___ Hypertension	Surgeries w/yr _____
___ Diabetes	___ Cancer	___ Stroke	Other _____

Social History

Occupation: _____			Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S		
Smoke Currently	Years of Smoking	Packs/Day	Alcohol Use:	Drinks/week	Recreational Drugs
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family Medical History: None (immediate relatives only: Mom, Dad & Siblings)

___ Heart Disease	___ High cholesterol	___ High blood pressure	___ Stroke
___ Diabetes	___ Cancer, specify type _____	Other _____	

Sign Here Please	Redi Care Provider (office use only)
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