ON DEMAND

Patient's Name: _____
DOB: _____
TODAY'S DATE: _____

REASON YOU ARE BEING SEEN TODAY: _____

Is this a follow-up visit? ☐ Yes ☐ No Do you need medication refills? ☐ Yes ☐ No

Have you traveled internationally lately? ☐ Yes ☐ No
If yes, where? _____ Dates of Travel _____

ALLERGIES:
Are you allergic to any medications? ☐ Yes ☐ No
If YES, please list all: _____

Do you have any other allergies ☐ Yes ☐ No

If YES, please list all: _____

MEDICATIONS:
Are you taking any medications, prescriptions or over the counter medications, right now? ☐ Yes ☐ No
If YES, please list all: (Please use back of form if additional space is needed)

Medication Name	Strength	Qty Taken at one time	Times taken per day

SOCIAL HISTORY:

Do you use tobacco?	☐ Yes, Everyday	☐ Yes, On Occasion	☐ No, Former User	☐ No, Never
Do you use illegal drugs?	☐ Yes, Everyday	☐ Yes, On Occasion	☐ No, Former User	☐ No, Never
Are you currently employed?	☐ Yes, Full Time	☐ Yes, Part Time	☐ No, Retired	☐ No, Other

FAMILY HISTORY: Does any of your immediate blood relatives (grandparents, parents, siblings) have any of the following conditions?

CONDITION	YES	NO	RELATIVE	CONDITION	YES	NO	RELATIVE
Diabetes				Osteoarthritis			
High Blood Pressure				Rheumatoid Arthritis			
Heart Disease				Heart Attack/Murmurs			
Cancer				Thyroid Disease			
Type				High Cholesterol			
Kidney Disease				Liver Disease			
Dementia				Stroke			

ON DEMAND

Patient's Name: _____
DOB: _____
TODAY'S DATE: _____

MEDICAL HISTORY:

Do you have any current medical conditions you are being treated for? ☐ Yes ☐ No

If YES, please list all: _____

_____

Do you have any past medical conditions you have been treated for? ☐ Yes ☐ No

If YES, please list all: _____

_____

SURGICAL HISTORY:

Have you ever had any surgeries? ☐ Yes ☐ No

If YES, please list all including date(s) and specify Right or Left if applicable _____

_____

HOSPITALIZATION HISTORY:

Have you ever been hospitalized overnight? ☐ Yes ☐ No

If YES, please list When, Where and Reason: _____

_____

ON DEMAND

Patient's Name: _____
DOB: _____
TODAY'S DATE: _____

GENERAL: **WHEN:**
- ☐ Good Health Lately _____
- ☐ Recent unexplained weight loss or gain _____
- ☐ Fever/Chills/Sweats _____
- ☐ Fatigue _____
- ☐ Headaches _____

EAR, NOSE, THROAT, MOUTH:
- ☐ Hearing loss or ringing _____
- ☐ Earache or drainage _____
- ☐ Chronic sinus problems/head congestion _____
- ☐ Swollen glands in neck _____
- ☐ Sore throat or voice changes _____
- ☐ Environmental Allergies _____

RESPIRATORY:
- ☐ Chronic or frequent coughs _____
- ☐ Spitting/Coughing up blood _____
- ☐ Asthma or Wheezing _____
- ☐ Shortness of Breath _____

MUSCULOSKELETAL:
- ☐ Joint Pain/Stiffness/Swelling/Warmth _____
- ☐ Weakness of Muscles or Joints _____
- ☐ Muscle Pain or Cramps _____
- ☐ Back Pain _____
- ☐ Difficulty Walking _____

NEUROLOGICAL:
- ☐ Light Headed or Dizziness _____
- ☐ Convulsions or Seizures _____
- ☐ Numbness or Tingling Sensations _____
- ☐ Tremors _____
- ☐ Stroke/TIA _____
- ☐ Head Injury _____

EDOCRINE:
- ☐ Gland or Hormonal Problems _____
- ☐ Thyroid Disease _____
- ☐ Problems with Blood Sugar/Diabetes _____
- ☐ Frequent Thirst for no reason _____
- ☐ Heat or Cold Intolerance _____

FOR WOMEN: GENITOURINARY
- ☐ Frequent Urination _____
- ☐ Burning/Painful Urination _____
- ☐ Frequent Urination at Night _____
- ☐ History of Kidney Infections/Stones _____
- ☐ Blood in Urine _____
- ☐ Vaginal Discharge/Odor/Itching _____
- ☐ Pain During Sex _____
- ☐ Lack of Sexual Desire _____
- ☐ Painful/Heavy Periods _____
- ☐ PMS or Menopausal Symptoms _____

EYES: **WHEN:**
- ☐ Eye Disease or injury _____
- ☐ Wear glasses or contacts _____
- ☐ Blurred Vision/Glaucoma/Cataracts _____
- ☐ Flashing Lights/Floaters _____
- ☐ Water/Itchy/Discharge from Eyes _____

CARDIOVASCULAR:
- ☐ Heart Problems _____
- ☐ Chest Pain _____
- ☐ Palpitations _____
- ☐ Shortness of Breath _____
- ☐ Swelling of ankles/hands/feet _____
- ☐ Passing out spells _____

GASTROINTESTINAL:
- ☐ Loss of Appetite _____
- ☐ Heartburn _____
- ☐ Nausea/Vomiting/Diarrhea/Constipation _____
- ☐ Change in Bowel Movements _____

SKIN:
- ☐ Rash or Itching _____
- ☐ Sunburns as a child _____
- ☐ Change in Skin Color/Moles _____
- ☐ Change in Hair or Nails _____
- ☐ Varicose Veins _____

PSYCHIATRIC:
- ☐ Memory Loss of Confusion _____
- ☐ Difficulty with Anger _____
- ☐ Nervousness _____
- ☐ Depression _____
- ☐ Trouble Sleeping _____
- ☐ Hospitalized for Emotional Problems _____

HEMATOLOGIC/LYMPHATIC:
- ☐ Slow Healing Cuts or Bruises _____
- ☐ Anemia _____
- ☐ Past Blood Transfusions _____
- ☐ Enlarged Lymph Nodes in Groin/Armpits _____
- ☐ Easier Bruising than usual for you _____

FOR MEN: GENITOURINARY
- ☐ Frequent Urination _____
- ☐ Burning/Painful Urination _____
- ☐ Frequent Urination at Night _____
- ☐ History of Kidney Infections/Stones _____
- ☐ Blood in Urine _____
- ☐ Erectile Dysfunction _____
- ☐ Testicular Pain _____
- ☐ Lack of Sexual Desire _____
- ☐ Discharge from Penis _____
- ☐ Pain During Sex _____