COASTAL HEALTHCARE

Name: _____ Date of Birth: _____ Todays Date: _____

Why are we seeing you today? _____

SURGICAL HISTORY

Procedure	Surgery Date	Notes

FAMILY HISTORY Please be specific if it is on the Maternal or Paternal side.

Relation	Problem

Relation	Problems

MEDICATIONS If not enough room, please list on back.

Pharmacy: _____

Medication/Dosage	Directions

Medication/Dosage	Directions

ALLERGIES

Drug/Allergen	Reaction

Drug/Allergen	Reaction

Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY (only mark if yes)

	Yes	Notes		Yes	Notes
ADHD			Heart Attack/MI (angina)		
Abdominal Pain			Heart Disease		
Abnormal Weight Loss			Heart Murmur/Valve Disorder		
Affective Disorders			Hemorrhoids		
Alcoholism			Hepatitis (Acute or Chronic)		
Allergies			Hernia(s)		
Anemia			High Cholesterol		
Anorexia			Hypertension		
Anxiety Disorder			Hyperthyroidism		
Aortic Aneurysm			Hypothyroidism		
Appendicitis			Incontinence: Fecal		
Appetite, poor			Incontinence: Urinary		
Arrhythmia			Indigestion		
Arthritis			Kidney Disease		
Asthma/Breathing Problems			Leg/Foot Ulcers		
a-fib			Liver Disease		
atrial flutter			MRSA		
Bladder or Kidney Problems			Measles		
Bleeding Disorder			Migraine Headaches		
Bloating			Miscarriage		
Blood Diseases			Mononucleosis		
Bowel changes			Mouth sores		
Breast Mass/Cyst			Multiple Sclerosis		
Broken Bones			Mumps		
Bronchitis			Muscle/Joint/Bone Problem		
Bulimia			Nasal Trauma		
CVA/ /Stroke			Nausea Alone		
Cancer			Nausea/Vomiting		
Carotid Disease			Organ Transplant		
Cataracts			Osteopenia		
Chemical/Drug Dependency			Osteoporosis		
Chickenpox			Pacemaker		
COPD			Peptic Ulcers		
Chronic Pain			Peripheral Vascular Problem		
Constipation			Pneumonia		
Coronary Artery Disease			Polio		
Deep Vein Thrombophlebitis			Poliomyelitis		
Depression			Post-Menopausal		
Developmental or Behavioral Disorders			Prostate Problems		
Diabetes			Psychiatric Care		
Dialysis			Pulmonary Embolism		
Diarrhea			Rectal Bleeding		
Difficulty swallowing			Reflux Disease		
Digestive Problems			Rheumatic Fever		

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Diverticulitis			**Scarlet Fever**		
Ear or Hearing Problems			**Seizures or Convulsions**		
Ectopic Pregnancy			**Serious/Traumatic Injuries**		
Emotional Problems			**Sexually Transmitted Disease**		
Emphysema			**Skin Cancer/Problems**		
Epilepsy			**Sleep Apnea (snoring)**		
Fibromyalgia			**Suicide Attempt**		
Gastrointestinal Disease			**shortness of breath**		
Genitourinary Disease			**Tonsillitis**		
GERD/Acid Reflux			**Tuberculosis**		
German Measles			**Typhoid Fever**		
Glaucoma			**Ulcers**		
Goiter			**Urinary Tract Infection**		
Gonorrhea			**Vaginal Infections**		
Gout			**Vision or Eye Problems**		
HIV Positive			**Vomiting blood**		
Headaches or Dizziness					

SOCIAL HISTORY

Occupation						**Notes**	
Education						**Notes**	
Able to Care for self?	Yes		No			**Notes**	
Alcohol intake	None	Occ	Mod	Heavy		**Yrs of use:**	
Special Diet (eg: vegan)						**Notes**	
Exercise level	None	Occ	Mod	Heavy		**Notes**	
Caffeine intake	None	Occ	Mod	Heavy		**Notes**	
DNR in place	Yes	No				**Notes**	
Live alone or with others						**Notes**	
Illicit drugs						**Yrs of use:**	
Stress level	Low	Med	High			**Notes**	
Sporting Activities						**Notes**	
Sexually active?	Yes		No			**Notes**	
Protective sex?	Yes		No			**Notes**	
Past History of Abuse	Yes		No			**Notes**	
Current Abuse	Yes		No			**Notes**	
Type of Abuse	Verbal		Physical	Emotional		**Notes**	
Smoking Status or chewing tobacco	Never	Former	Current Daily	Current Sporadic		**Yrs of use**	How much:

Date of Last Flu Shot: _____ **Date of Last Pneumonia Vaccine: _____**

Colon Cancer Screening: **Date Screened _____**

Screen Type: ☐ **Colonoscopy** ☐ **Flexible Sigmoidoscopy** ☐ **Fecal Occult Blood Testing**

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FEMALE PATIENTS ONLY:

GYN HISTORY

First day of Last Period		**Notes**	
Age at First Child		**Notes**	
Current Birth Control Method		**Notes**	
Frequency of Cycle (Q days)		**Notes**	
Age at Menarche (First Menstruation)		**Notes**	
Flow	Light Med Heavy	**Notes**	
Duration of Flow (days)		**Notes**	
If Post-Menopausal, Age at Menopause		**Notes**	
Menses Monthly		**Notes**	
Date of last Pap?		**Notes**	
Date of last Mammogram		**Notes**	
Do you do self-breast exam?	Yes No	**Notes**	

PAST PREGNANCIES

Date	Gestational Age (Weeks)	Labor Length (Hours)	Birth Weight	Sex	Delivery Type c/section or vaginal	Outcome Full-Term Birth Pre-Mature Birth Abortion Miscarriage Ectopic Fetal Demise	Anesthesia General Local Epidural Spinal None	Delivery Place	Complications

Name_____Date of Birth_____Date_____

COASTAL HEALTHCARE

Review of Systems

Do you currently have any problems related to the following systems? Circle **Yes** or **No**

Please explain any Yes answers in the space provided.

Constitutional Symptoms				**Skin**			
Fever	Yes	No		Skin Rash	Yes	No	
Chills	Yes	No		Boils	Yes	No	
Headache	Yes	No		Persistent Itch	Yes	No	
Other				Other			
Eyes				**Musculoskeletal**			
Blurred Vision	Yes	No		Joint Pain	Yes	No	
Double Vision	Yes	No		Neck Pain	Yes	No	
Pain	Yes	No		Back Pain	Yes	No	
Other				Other			
Allergic/Immunologic				**Ears/Nose/Throat/Mouth**			
Hay Fever	Yes	No		Ear Infection	Yes	No	
Drug Allergies	Yes	No		Sore Throat	Yes	No	
Other				Sinus Problems	Yes	No	
Neurological				Other			
Tremors	Yes	No		**Respiratory**			
Dizzy Spells	Yes	No		Wheezing	Yes	No	
Numbness/Tingling	Yes	No		Frequent cough	Yes	No	
Other				Shortness of breath	Yes	No	
Endocrine				Other			
Excessive	Yes	No					
Too Hot/Cold	Yes	No		**Hematologic/Lymphatic**			
Tired/Sluggish	Yes	No		Swollen glands	Yes	No	
Other				Blood clotting problem	Yes	No	
Gastrointestinal				Other			
Abdominal pain	Yes	No		**Psychologic**			
Nausea/Vomitinq	Yes	No		Are you generally satisfied with your life?	Yes	No	
Indigestion/heartburn	Yes	No		Do you feel severely depressed?	Yes	No	
Other				Have you considered suicide?	Yes	NO	
Cardiovascular				Other			
Chest pain	Yes	No					
Varicose Veins	Yes	No					
High Blood Pressure	Yes	No					
Other							

(Comments/Notes)

	#Answer	Level of Service
	0-1	1 or 2
	2-9	3
	10+	4or5

Physician: Date / /