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	Problem

☐ **Any bleeding problems in your family: _____**

☐ **Any problems with anesthesia in your family: _____**

☐ **Family history of blood clots: _____**

☐ **Family History of cancer: _____**

MEDICATIONS If not enough room, please list on back.

Pharmacy: _____

☐ **Any blood thinners or aspirin. If so, specify: _____**

Medication/Dosage	Directions

Medication/Dosage	Directions

Name: _____ **Date of Birth:** _____

ALLERGIES

Drug/Allergen	Reaction

Drug/Allergen	Reaction

PAST MEDICAL HISTORY (ONLY mark if YES)

	Yes	Notes		Yes	Notes
ADHD			Developmental/Behavioral Disorders		
Abdominal Pain			Diabetes		
Abnormal Weight Loss			Dialysis		
Affective Disorders			Diarrhea		
Alcohol Use			Difficulty Swallowing		
Allergies			Digestive Problems		
Anemia			Diverticulitis		
Anorexia			Ear or Hearing Problems		
Anxiety Disorder			Ectopic Pregnancy		
Aortic Aneurysm			Emotional Problems		
Appendicitis			Emphysema		
Appetite, poor			Epilepsy		
Arrhythmia			Fibromyalgia		
Arthritis			Gastrointestinal Disease		
Asthma/Breathing Problems			GERD/ Acid Reflux		
Atrial-Fib			German Measles		
Atrial Flutter			Glaucoma		
Bladder or Kidney Problems			Goiter		
Bleeding Disorder			Gonorrhea		
Bloating			Gout		
Blood Disease			HIV Positive		
Bowel Changes			Headaches or Dizziness		
Breast Mass / Cyst			Heart Attack/ MI (angina)		
Broken Bones			Heart Disease		
Bronchitis			Heart Murmur/ Valve Disorder		
Bulimia			Hemorrhoids		
CVA / Stroke			Hepatitis (Acute or Chronic)		
Cancer			Hernia(s)		
Carotid Disease			High Cholesterol		
Cataracts			Hypertension		
Chemical / Drug Dependency			Hyperthyroidism		
Chicken Pox			Hypothyroidism		
COPD			Incontinence: Fecal		
Chronic Pain			Incontinence: Urinary		
Constipation			Indigestion		
Coronary Artery Disease			Kidney Disease		
Deep Vein Thrombosis			MRSA/ Drug Resistant Infections		
Depression			Measles		

Name: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY (continued)

Migraine Headaches			**Pulmonary Embolism**		
Miscarriage			**Rectal Bleeding**		
Mononucleosis			**Reflux Disease**		
Mouth Sores			**Rheumatic Fever**		
Multiple Sclerosis			**Scarlet Fever**		
Mumps			**Seizures or Convulsions**		
Muscle/ Joint/ Bone Problem			**Serious/ Traumatic Injuries**		
Nasal Trauma			**Sexually Transmitted Disease**		
Nausea Alone			**Skin Cancer**		
Nausea/ Vomiting			**Skin Problems**		
Organ Transplant			**Sleep Apnea (snoring)**		
Osteopenia			**Suicide Attempt**		
Osteoporosis			**Shortness of Breath**		
Pacemaker			**Tonsilitis**		
Peptic Ulcers			**Tuberculosis**		
Peripheral Vascular Problem			**Typhoid Fever**		
Pneumonia			**Ulcers**		
Polio			**Urinary Tract Infections**		
Poliomyelitis			**Vaginal Infections**		
Post-Menopausal			**Vision or Eye Problems**		
Prostate Problems			**Vomiting Blood**		
Psychiatric Care			**Other:**		

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:**		
Recreational Drugs/Products					**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/ Vaping chewing tobacco	Never	Former	Current Daily	Current Sporadic	**Yrs of use:**	How much:	

Name: _____ **Date of Birth:** _____

Date of Last Flu Shot: _____

Date of Last Pneumonia Vaccine: _____

Colon Cancer Screening: **Yes:** ☐ **No:** ☐ **Date Screened:** _____

Screen Type:

☐ **Colonoscopy** ☐ **Flexible Sigmoidoscopy** ☐ **Fecal Occult Blood Testing**

Any Polyps or Biopsies done: Yes: ☐ **No:** ☐ **Specify:** _____

Abnormal Findings: _____

Do you have allergies to any of the following:

☐ **Latex**

☐ **Iodine, when:** _____

☐ **IV Contrast, when:** _____

☐ **Adhesives, type:** _____

☐ **No known Allergies**

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	/ /