Reason for Consultation: ☐ Arthritis ☐ Asthma ☐ Auto Accident ☐ Check Up ☐ Diabetes ☐ Emphysema ☐ Follow up
☐ HTN ☐ Hyperlipidemia ☐ Allergies ☐ ASHD ☐ Fatigue ☐ Malaise ☐ Thyroid Ds Other_____

Chief Complaint:_____

If Symptom Includes Pain Check The One(s) That Best Describe: ☐ Aching ☐ Burning ☐ Continuous ☐ Cramping ☐ Deep ☐ Dull ☐ Gnawing
☐ Gradual ☐ Intermittent ☐ Mild ☐ Moderate ☐ Periodic ☐ Sharp ☐ Shifting ☐ Stabbing ☐ Sudden ☐ Superficial Other_____

Duration:_____**Location(s):**_____**Historian**_____

Date Symptom(s) Began_____**Frequency of Sympstom(s):** ☐___x Per Day ☐___x Per Week ☐ ___x Per Month ☐___x Per Month

☐ Constant ☐ Intermittent ☐ Occasional ☐ Rare ☐ Recurrent Other_____

Intensity Of Symptoms: ☐ Excruciating ☐ Mild ☐ Moderate ☐ Severe Other_____

How Did Symptom(s) Start:_____

How Did Symptom(s) Progress:_____

What Brings It On:_____ **What Makes It Worse:**_____

What Relieves It:_____**Associated Symptom(s):**_____

Antibiotic Usage:_____

Comments:_____
_____
_____
_____
_____

Medications – List all medications you are currently taking. Include **ALL** medications even the Over The Counter ones.

Drug Name (Generic/Brand)	Dosage	Frequency	Status
d	dddd		☑ Current ☐ Chronic ☐ DC'd
d			☐ Current ☐ Chronic ☐ DC'd
d			☐ Current ☐ Chronic ☐ DC'd
d			☐ Current ☐ Chronic ☐ DC'd
d			☐ Current ☐ Chronic ☐ DC'd
			☐ Current ☐ Chronic ☐ DC'd
			☐ Current ☐ Chronic ☐ DC'd

Prevention

Do you wear seatbelts?	☐No	☐Yes	If no, why not?_____
Do you wear a bike helmet?	☐No	☐Yes	☐N/A
Do you smoke?	☐No	☐Yes	If yes, how many packs per day?_____
Do you drink alcoholic beverages?	☐No	☐Yes	If yes, how many per week?_____
Do you drink coffee?	☐No	☐Yes	If yes, how many cups per day?_____
Do you drink tea?	☐No	☐Yes	If yes, how many cups per day?_____
If there is a gun in your home, is it out of children's reach and unloaded?	☐No	☐Yes	☐N/A
Do you use drugs? (marijuana, cocaine, crack, etc)	☐No	☐Yes	If yes, explain:_____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐No	☐Yes	If yes, explain:_____
Do you wish to be tested for AIDS?	☐No	☐Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	☐No	☐Yes	If yes, explain:_____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐No	☐Yes	
Do you ever feel afraid of your partner?	☐No	☐Yes	
Do you have a "living will"?	☐No	☐Yes	
Do you have a donor card?	☐No	☐Yes	

Method of birth control?_____