Patient Name: _____

Date of Birth: _____ Today's Date: _____

☐ No changes to medical, family and social history since last visit.

# Patient Medical History and Symptoms Inventory

Briefly explain the reason for coming to FastMed today (include duration, severity and location):_____

_____

Is your visit related to a work injury? ☐ Yes ☐ No

## CURRENT MEDICATIONS/DOSAGES INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS

Please list below. The front desk can photocopy and attach your list of medications if you have it with you. ☐ Check here if none

_____

## ALLERGIES

Please list below as well as the reactions you experience. ☐ Check here if none

_____

## MEDICAL HISTORY

Please mark those that you have or had in the past. ☐ Check here if none

| | | | |
|---|---|---|---|
| ☐ Arthritis | ☐ Gastrointestinal Problems | ☐ Kidney Problems | ☐ Psychiatric |
| ☐ Blood Disorder | ☐ Genitourinary/Prostate | ☐ Liver Problems, Hepatitis | ☐ Cancer |
| ☐ Sexually Transmitted Dis. | ☐ Heart Problems | ☐ Lung Problems | ☐ Skin Disease |
| ☐ Diabetes | ☐ High Blood Pressure | ☐ Musculoskeletal | ☐ Thyroid |
| ☐ Ear/Nose/Throat Problems | ☐ High Cholesterol | ☐ Neurologic (stroke, seizure) | ☐ Respiratory |

☐ Other, please specify: _____

## SURGICAL HISTORY

Please mark those that you have or had in the past. ☐ Check here if none

| | | |
|---|---|---|
| ☐ Head/Neck/Breast | ☐ Abdominal/Pelvic | ☐ Bone/Joint |
| ☐ Heart/Lung | ☐ Spine | |

☐ Other, please specify: _____

Please provide procedure name and year: _____

## SOCIAL HISTORY

Please mark those that apply.

| | | | |
|---|---|---|---|
| ☐ Tobacco: Cigs/day _____ Years of Use _____ | ☐ Alcohol: Drinks/day _____ Years of Use _____ | ☐ Street/Non-prescribed Drugs ☐ Sexually Active | ☐ Recent Travel |

## FAMILY HISTORY

Please complete for those family members that have a significant medical condition. ☐ Check here if none

Father _____ Brother/Sister _____

Mother _____ Other _____

## IMMUNIZATIONS

Date of last tetanus (if known) _____ Are childhood immunizations up-to-date? (as appropriate) ☐ Yes ☐ No

Other: _____

## FEMALE PATIENTS

Last Menstrual Period: Month: _____ Day: _____

**TO BE COMPLETED BY CLINIC STAFF**

Wt (in kg): _____ HT: _____ TEMP: _____ ROUTE: _____

P: _____ R: _____ O2SAT: _____% BP: _____/_____

**REVIEW OF TODAY'S SYMPTOMS** – THIS SECTION FOR OFFICE USE ONLY:

## CONSTITUTIONAL

☐ No ☐ Yes Change in appetite
☐ No ☐ Yes Chills
☐ No ☐ Yes Fatigue
☐ No ☐ Yes Fever
☐ No ☐ Yes Sweats
☐ No ☐ Yes Weight Loss

## CARDIOVASCULAR

☐ No ☐ Yes Chest Pain/Pressure
☐ No ☐ Yes Fainting
☐ No ☐ Yes Fluttering/Palpitations
☐ No ☐ Yes Leg Swelling

## NEUROLOGICAL

☐ No ☐ Yes Headache
☐ No ☐ Yes Light Headedness
☐ No ☐ Yes Loss of Consciousness
☐ No ☐ Yes Numbness/Tingling
☐ No ☐ Yes Poor Balance
☐ No ☐ Yes Weakness

## PSYCHIATRIC

☐ No ☐ Yes Anxiety/Nerves
☐ No ☐ Yes Depression
☐ No ☐ Yes Sleep Difficulties

## LYMPH

☐ No ☐ Yes Easy Bleeding
☐ No ☐ Yes Frequent Infections
☐ No ☐ Yes Nodes/Glands

## EYES

☐ No ☐ Yes Blurred Vision
☐ No ☐ Yes Contact Lens
☐ No ☐ Yes Double Vision
☐ No ☐ Yes Eye Discharge
☐ No ☐ Yes Eye Pain
☐ No ☐ Yes Eye Redness
☐ No ☐ Yes Eye Swelling
☐ No ☐ Yes Eyeglasses

## ENT AND MOUTH

☐ No ☐ Yes Difficulty Swallowing
☐ No ☐ Yes Dizziness
☐ No ☐ Yes Ear Pain
☐ No ☐ Yes Hoarseness
☐ No ☐ Yes Mouth Pain
☐ No ☐ Yes Nasal Congestion
☐ No ☐ Yes Nose Discharge
☐ No ☐ Yes Sore Throat

## RESPIRATORY

☐ No ☐ Yes Congestion
☐ No ☐ Yes Cough
☐ No ☐ Yes Shortness of Breath
☐ No ☐ Yes Snoring
☐ No ☐ Yes Wheeze

## GASTROINTESTINAL

☐ No ☐ Yes Abdominal Pain
☐ No ☐ Yes Blood in Stools
☐ No ☐ Yes Constipation
☐ No ☐ Yes Diarrhea
☐ No ☐ Yes Nausea
☐ No ☐ Yes Rectal/Perirectal Complaints
☐ No ☐ Yes Urinary/Bowel Changes
☐ No ☐ Yes Vomiting

## GENITOURINARY

☐ No ☐ Yes Blood in Urine
☐ No ☐ Yes Discharge
☐ No ☐ Yes Frequent Urination
☐ No ☐ Yes Nighttime Urination
☐ No ☐ Yes Painful Urination
☐ No ☐ Yes Sexual Difficulties

## MUSCULOSKELETAL

☐ No ☐ Yes Back Pain
☐ No ☐ Yes Joint Pain
☐ No ☐ Yes Muscle Pain
☐ No ☐ Yes Swelling

## SKIN

☐ No ☐ Yes Bruising
☐ No ☐ Yes Itching
☐ No ☐ Yes Laceration
☐ No ☐ Yes Rash
☐ No ☐ Yes Redness
☐ No ☐ Yes Skin Sores

## ENDOCRINE

☐ No ☐ Yes Abnormal Blood Sugar
☐ No ☐ Yes Cold Intolerance
☐ No ☐ Yes Excessive Hunger/Thirst
☐ No ☐ Yes Hair Loss
☐ No ☐ Yes Heat Intolerance
☐ No ☐ Yes Hot Flashes

## ALLERGY/IMMUNE

☐ No ☐ Yes Itchy Eyes
☐ No ☐ Yes Lip/Tongue/Throat Swelling
☐ No ☐ Yes Post-nasal Drop
☐ No ☐ Yes Sneezing