

INITIAL CONSULT WORKSHEET

Patient Name _____ DOB _____ Date: _____

Did a physician refer you YES NO

Referring Physician's Name _____ Phone _____

Address _____ City/Zip. _____

MEDICINES

(currently used regularly or occasionally) List non-prescription medicines on last line. (None)

Name of Medicine	Dose (mg)	Frequency of use (times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Have you had any reactions to:

Latex, rubber, or adhesive tape Yes No Seafood, iodine, or contrast dye for x-rays Yes No

Bee stings Yes No Hives, skin rash, trouble breathing, or other severe reactions to medicines Yes No

If "Yes" to the last question, list below:

Medicine/other substance	Type of reaction
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Highest education level (grade) attained G.E.D. H.S.Diploma College Degree _____ Other _____

Are you presently employed Yes No Occupation _____

Prior Occupations _____

Have you had any occupational exposure to asbestos, metals, chemicals, etc. Yes No

If Yes, Describe _____

Do you smoke tobacco Yes No Type & frequency _____ How long _____

In the past Yes No Type & frequency _____ How long _____

When stopped _____ Did your mother smoke Yes No Did your father smoke Yes No

Do you drink alcohol Yes No Type & frequency _____ How long _____

In the past Yes No Type & frequency _____ How long _____

When stopped _____

HOME ENVIRONMENT/COMMUNICATION ASSESSMENT

(Physician: Elaborate when appropriate)

Are you currently married Yes No if yes, how long _____ Divorced Widowed Single

Do you have problems with your

Ability to see Yes No Describe _____ Do you wear glasses/contacts Yes No

Ability to speak Yes No Describe _____ Do you have speaking aids Yes No

Ability to hear Yes No Describe _____ Do you have hearing aids Yes No

Patient Name _____

REVIEW OF SYSTEMS

- Headaches, confusion, memory lapses, seizures, slurred speech, Yes No
- Arm or leg weakness Yes No
- Vision loss or blurring, double vision; eye pain Yes No
- Non-healing or slow healing sore in mouth (gums, tongue, throat, etc.) Yes No
- Hoarseness; weakness or loss of voice Yes No
- New cough or change in usual cough Yes No
- Coughed up blood (plain or mixed with spit) Yes No
- Chest pain or pressure; irregular or rapid heart beat; heart valve Yes No
- Swelling in legs or feet; pain in the calves when walking Yes No
- Loss of appetite: change in taste; fill up early when eating Yes No
- Difficulty or pain while chewing, drinking, or swallowing Yes No
- Indigestion, heartburn, nausea, vomiting, or stomach trouble Yes No
- Significant diarrhea or constipation; recent change in bowel habits Yes No
- Blood in stool or tarry looking stool Yes No
- Skin rash or sore: change in a mole Yes No
- Pain, stiffness, swelling or heat in joints; pain in any bone or back Yes No
- Pain anywhere else in the body Yes No
- Anxiety, depression, trouble falling asleep or staying asleep Yes No
- Any lumps or bumps (skin, lymph nodes or glands, breasts, testicles, etc.) Yes No
- Easy or excessive fatigue Yes No
- Fever or night sweats Yes No
- Itching Yes No
- Abdominal swelling or bloating Yes No
- New moles or change in a mole Yes No
- Diabetes; thyroid or adrenal problems Yes No
- Excessive bleeding or bruising Yes No

Physician Comments

Usual weight _____ lbs. Wt. lost in last 6 months _____ lbs. Wt. lost in last 3 months _____

FEMALES ONLY

- Mammogram within 1 year Yes No Date of last mammogram _____
- Pelvic exam within 1 year Yes No Date of last pelvic exam _____
- Pap smear within 1 year Yes No Date of last pap smear _____
- Still menstruating Yes No Age when started menstruation _____
- If Yes, regular periods Yes No Blood loss/pattern typical Yes No
- If No, natural menopause Yes No Surgical menopause Yes No Age _____
- Other _____
- Might you be pregnant Yes No
- Have you ever been pregnant Yes No If yes, how many times _____
- Age at first pregnancy _____ Age at last pregnancy _____ Age of first menstrual period _____
- Are you taking any hormones Yes No If yes, what hormones are you taking _____

Abortions Yes No Miscarriages Yes No If Yes, explain below _____

MALES ONLY

- Prostate exam within 1 year Yes No Date of last prostate exam _____
- PSA within 1 year Yes No If Yes, was it Normal Abnormal
- Any trouble with starting urine, dribbling, getting up more than 2x/night to urinate Yes No

Patient Name _____

PAST MEDICAL HISTORY

(Physician: Elaborate in comments or in notes when appropriate)

Have you ever had any of the following illnesses or conditions in the past?

	<u>Comments</u>				<u>Comments</u>	
Stroke/TIA	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver disease/hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Glaucoma/Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney/Bladder disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Thyroid disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood fats, cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abnormal bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Vein trouble/blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Female problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Prostate problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis, pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Stomach/bowel disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lymphoma/Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Autoimmune disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had any serious injuries or broken bones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____			
Have you ever received a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____			
Immunizations						
Flu (within 1 year)	<input type="checkbox"/> Yes	Year _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown		
Hepatitis B	<input type="checkbox"/> Yes	Year _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown		
Pneumonia	<input type="checkbox"/> Yes	Year _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown		
Tetanus (w/in 10 yrs)	<input type="checkbox"/> Yes	Year _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown		

SURGERY

(Please list all prior surgeries and hospitalization dates)

FAMILY HISTORY

(Physician: Elaborate in comments or in notes when appropriate)

Father alive Yes No Age _____ If No, age of death _____ Cause of death _____
 Mother alive Yes No Age _____ If No, age of death _____ Cause of death _____
 Any brothers Yes No How many alive _____ Age(s) _____
 How many deceased? _____ Age(s) _____ Cause of death _____
 Any sisters Yes No How many alive _____ Age(s) _____
 How many deceased? _____ Age(s) _____ Cause of death _____
 Any children Yes No How many alive _____ Age(s) _____
 How many deceased? _____ Age(s) _____ Cause of death _____

Father's race:
 White (not Hispanic origin) Black (not Hispanic origin) Hispanic Asian/Pacific Islander Native American/Native Alaskan

Mother's race:
 White (not Hispanic origin) Black (not Hispanic origin) Hispanic Asian/Pacific Islander Native American/Native Alaskan

Indicate illnesses which have occurred in Parents, Grandparents, Aunts, Uncles, Brothers, Sisters

	<u>Identify Family Members</u>	<u>Physician's Comments</u>
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bowel disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient's signature _____ Date _____
 Signature of person assisting patient with this form _____ Date _____
 Relationship to patient _____