

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

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Genitourinary/Prostate | <input type="checkbox"/> Liver Problems, Hepatitis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sexually Transmitted Dis. | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Ear/Nose/Throat Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Neurologic (stroke, seizure) | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Other, please specify: _____ | | | |

SURGICAL HISTORY

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

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Head/Neck/Breast | <input type="checkbox"/> Abdominal/Pelvic | <input type="checkbox"/> Bone/Joint |
| <input type="checkbox"/> Heart/Lung | <input type="checkbox"/> Spine | |
| <input type="checkbox"/> Other, please specify: _____ | | |

Please provide procedure name and year: _____

SOCIAL HISTORY

Please mark those that apply.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Tobacco: Cigs/day _____ Years of Use _____ | <input type="checkbox"/> Alcohol: Drinks/day _____ Years of Use _____ | <input type="checkbox"/> Street/Non-prescribed Drugs | <input type="checkbox"/> Recent Travel |
| <input type="checkbox"/> Sexually Active | | | |

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

- | | | |
|---|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Change in appetite | <input type="checkbox"/> No <input type="checkbox"/> Yes Chills | <input type="checkbox"/> No <input type="checkbox"/> Yes Fatigue |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Fever | <input type="checkbox"/> No <input type="checkbox"/> Yes Sweats | <input type="checkbox"/> No <input type="checkbox"/> Yes Weight Loss |

CARDIOVASCULAR

- | | | |
|--|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Chest Pain/Pressure | <input type="checkbox"/> No <input type="checkbox"/> Yes Fainting | <input type="checkbox"/> No <input type="checkbox"/> Yes Fluttering/Palpitations |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Leg Swelling | | |

NEUROLOGICAL

- | | | |
|--|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Headache | <input type="checkbox"/> No <input type="checkbox"/> Yes Light Headedness | <input type="checkbox"/> No <input type="checkbox"/> Yes Loss of Consciousness |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Numbness/Tingling | <input type="checkbox"/> No <input type="checkbox"/> Yes Poor Balance | <input type="checkbox"/> No <input type="checkbox"/> Yes Weakness |

PSYCHIATRIC

- | | | |
|---|---|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Anxiety/Nerves | <input type="checkbox"/> No <input type="checkbox"/> Yes Depression | <input type="checkbox"/> No <input type="checkbox"/> Yes Sleep Difficulties |
|---|---|---|

LYMPH

- | | | |
|--|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Easy Bleeding | <input type="checkbox"/> No <input type="checkbox"/> Yes Frequent Infections | <input type="checkbox"/> No <input type="checkbox"/> Yes Nodes/Glands |
|--|--|---|

EYES

- | | | |
|---|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Blurred Vision | <input type="checkbox"/> No <input type="checkbox"/> Yes Contact Lens | <input type="checkbox"/> No <input type="checkbox"/> Yes Double Vision |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Eye Discharge | <input type="checkbox"/> No <input type="checkbox"/> Yes Eye Pain | <input type="checkbox"/> No <input type="checkbox"/> Yes Eye Redness |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Eye Swelling | <input type="checkbox"/> No <input type="checkbox"/> Yes Eyeglasses | |

ENT AND MOUTH

- | | | |
|--|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Difficulty Swallowing | <input type="checkbox"/> No <input type="checkbox"/> Yes Dizziness | <input type="checkbox"/> No <input type="checkbox"/> Yes Ear Pain |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Hoarseness | <input type="checkbox"/> No <input type="checkbox"/> Yes Mouth Pain | <input type="checkbox"/> No <input type="checkbox"/> Yes Nasal Congestion |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Nose Discharge | <input type="checkbox"/> No <input type="checkbox"/> Yes Sore Throat | |

RESPIRATORY

- | | | |
|---|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Congestion | <input type="checkbox"/> No <input type="checkbox"/> Yes Cough | <input type="checkbox"/> No <input type="checkbox"/> Yes Shortness of Breath |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Snoring | <input type="checkbox"/> No <input type="checkbox"/> Yes Wheeze | |

GASTROINTESTINAL

- | | | |
|--|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Abdominal Pain | <input type="checkbox"/> No <input type="checkbox"/> Yes Blood in Stools | <input type="checkbox"/> No <input type="checkbox"/> Yes Constipation |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Diarrhea | <input type="checkbox"/> No <input type="checkbox"/> Yes Nausea | <input type="checkbox"/> No <input type="checkbox"/> Yes Rectal/Perirectal Complaints |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Urinary/Bowel Changes | <input type="checkbox"/> No <input type="checkbox"/> Yes Vomiting | |

GENITOURINARY

- | | | |
|--|--|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Blood in Urine | <input type="checkbox"/> No <input type="checkbox"/> Yes Discharge | <input type="checkbox"/> No <input type="checkbox"/> Yes Frequent Urination |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Nighttime Urination | <input type="checkbox"/> No <input type="checkbox"/> Yes Painful Urination | <input type="checkbox"/> No <input type="checkbox"/> Yes Sexual Difficulties |

MUSCULOSKELETAL

- | | | |
|--|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Back Pain | <input type="checkbox"/> No <input type="checkbox"/> Yes Joint Pain | <input type="checkbox"/> No <input type="checkbox"/> Yes Muscle Pain |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Swelling | | |

SKIN

- | | | |
|---|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Bruising | <input type="checkbox"/> No <input type="checkbox"/> Yes Itching | <input type="checkbox"/> No <input type="checkbox"/> Yes Laceration |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Rash | <input type="checkbox"/> No <input type="checkbox"/> Yes Redness | <input type="checkbox"/> No <input type="checkbox"/> Yes Skin Sores |

ENDOCRINE

- | | | |
|---|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Abnormal Blood Sugar | <input type="checkbox"/> No <input type="checkbox"/> Yes Cold Intolerance | <input type="checkbox"/> No <input type="checkbox"/> Yes Excessive Hunger/Thirst |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Hair Loss | <input type="checkbox"/> No <input type="checkbox"/> Yes Heat Intolerance | <input type="checkbox"/> No <input type="checkbox"/> Yes Hot Flashes |

ALLERGY/IMMUNE

- | | | |
|---|---|--|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Itchy Eyes | <input type="checkbox"/> No <input type="checkbox"/> Yes Lip/Tongue/Throat Swelling | <input type="checkbox"/> No <input type="checkbox"/> Yes Post-nasal Drop |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Sneezing | | |