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Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

PATIENT INFORMATION

Patient Name:		Date:
DOB:	Height:	Weight:
Referring Physician:		Primary Care Physician:

I. Have you had any new diagnosis in the last 12 months? Yes No

Please list: _____

Social History

In the last 12 months have you seen another physician? If so, who?

Have you had any surgeries? Please list.

Have you had any change to medication or new medication allergies?

If you are diabetic, have any of the following been performed in the past 12 months?

Dilated eye exam Yes No

Diabetic foot exam Yes No

Micro albumin Yes No

How often do you use caffeine? None 1-2 per day 3-4 per day 5+ per day

Do you drink alcohol regularly? Yes No

How many drinks per day? <1 drink 1 drink 2-3 drinks 4+ drinks

Have you ever felt like you should cut back? Yes No

Do you have a history of substance abuse? Yes No

Have you ever had a blood transfusion? Yes No

Do you participate in sports/recreational activities? Yes No

If yes, please list _____.

Are you married or in a monogamous relationship? Yes No

Do you observe “safe sex” practices 100% of the time? Yes No

Do you have any children? Yes No

How many? _____ Names and Ages: _____

Are they healthy? Yes No

Do you wear a seatbelt when you are in the car? Yes No

Where were you born? _____

Have you lived in any other countries? Yes No

If Yes, where? _____

Family History

Mother **DOB:** _____ Living Deceased

Diabetes Stroke Osteoporosis High Blood Pressure

Arthritis Colon Cancer Breast Cancer Ovarian Cancer

Prostate Cancer Skin Cancer High Cholesterol Heart Attack/Disease

Other _____

Father **DOB:** _____ Living Deceased

Diabetes Stroke Osteoporosis High Blood Pressure

Arthritis Colon Cancer Breast Cancer Ovarian Cancer

Prostate Cancer Skin Cancer High Cholesterol Heart Attack/Disease

Other _____

Paternal Grandmother

Diabetes Stroke Osteoporosis High Blood Pressure

Arthritis Colon Cancer Breast Cancer Ovarian Cancer

Prostate Cancer Skin Cancer High Cholesterol Heart Attack/Disease

Other _____

Maternal Grandmother

Diabetes Stroke Osteoporosis High Blood Pressure

Arthritis Colon Cancer Breast Cancer Ovarian Cancer

Prostate Cancer Skin Cancer High Cholesterol Heart Attack/Disease

Other _____

Paternal Grandfather

Diabetes Stroke Osteoporosis High Blood Pressure

Arthritis Colon Cancer Breast Cancer Ovarian Cancer

Prostate Cancer Skin Cancer High Cholesterol Heart Attack/Disease

Other _____

Maternal Grandfather

Diabetes Stroke Osteoporosis High Blood Pressure

Arthritis Colon Cancer Breast Cancer Ovarian Cancer

Prostate Cancer Skin Cancer High Cholesterol Heart Attack/Disease

Other _____

Siblings**Sisters: # of** _____**brothers: # of** _____

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Attack/Disease |
| <input type="checkbox"/> Other _____ | | | |

Immunizations:**Date(s):**

- | | | | |
|---------------------------|------------------------------|-----------------------------|-------|
| Tetanus in last 10 years | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hepatitis A | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Hepatitis B | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Chicken Pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Have you had chicken pox? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Influenza | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| HPV vaccine | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

To help your doctor during today's health exam, please complete items 1 through 6.

If you are female complete below, otherwise skip to next page:

1.) Age: _____

First day of last menstrual (or first year of menstruation, if through menopause): _____

- 2.) Number of times pregnant: Zero 1-2 3-5 >6
 Number of completed Pregnancies: Zero 1 2 3 4 or >

If you are under the age of 55, what method of birth control do you use?

- | | | | |
|-------------------------------|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Condom | <input type="checkbox"/> Pill | <input type="checkbox"/> NuvaRing |
| <input type="checkbox"/> IUD | <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Tubal ligation |

Are you planning a pregnancy in the next 6-12 months? Yes No

3.) If you are through menopause or over age 50, do you take any of the following pills?

- | | | |
|------------------------|------------------------------|-----------------------------|
| Vitamin D | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calcium | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Estrogen (Premarin) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Progesterone (Provera) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

4.) Have you had any of the following problems:

Abnormal Pap smears: Yes No

If yes, Date: _____ Problem: _____

For abnormality, did you have any of the following?

- | | | |
|------------|------------------------------|-----------------------------|
| Colposcopy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Biopsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever had a mammogram? Yes No

Have you had any abnormal mammograms? Yes No

If yes, Date: _____ Problem: _____

For abnormality, did you have any of the following?

- | | | | | |
|--------------------|-----------------------|-----|-----------------------|----|
| Biopsy | <input type="radio"/> | Yes | <input type="radio"/> | No |
| Cyst fluid drained | <input type="radio"/> | Yes | <input type="radio"/> | No |
| Surgery | <input type="radio"/> | Yes | <input type="radio"/> | No |

5.) Do you have any of the following?

- | | | | | |
|--|-----------------------|-----|-----------------------|----|
| Problems with present method of birth control | <input type="radio"/> | Yes | <input type="radio"/> | No |
| Bleeding between periods or since periods stopped | <input type="radio"/> | Yes | <input type="radio"/> | No |
| A new or enlarging lump in breast | <input type="radio"/> | Yes | <input type="radio"/> | No |
| Change in size/color of a mole | <input type="radio"/> | Yes | <input type="radio"/> | No |
| Conflict in your family or relationships,
Sometimes handled by pushing, hitting, or cruelty | <input type="radio"/> | Yes | <input type="radio"/> | No |

6.) Osteoporosis (bone density) screening:

Is there a history of any relatives with the following:

- | | | | | |
|--|-----------------------|-----|-----------------------|----|
| Stooping over or losing height as they got older | <input type="radio"/> | Yes | <input type="radio"/> | No |
| “thin bones”, or hip fractures? | <input type="radio"/> | Yes | <input type="radio"/> | No |

Prevention:

Which of the following are included in your diet?

- | | | | | | | |
|---------------------|-----------------------|-------|-----------------------|------|-----------------------|-----|
| Grains and starches | <input type="radio"/> | A lot | <input type="radio"/> | Some | <input type="radio"/> | Few |
| Vegetables | <input type="radio"/> | A lot | <input type="radio"/> | Some | <input type="radio"/> | Few |
| Dairy Foods | <input type="radio"/> | A lot | <input type="radio"/> | Some | <input type="radio"/> | Few |
| Meats | <input type="radio"/> | A lot | <input type="radio"/> | Some | <input type="radio"/> | Few |
| Sweets | <input type="radio"/> | A lot | <input type="radio"/> | Some | <input type="radio"/> | Few |

Exercise:

- | | | | | | | | | |
|------------------|-----------------------|---------|-----------------------|-----------|-----------------------|-----------|-----------------------|---------|
| Do you exercise? | <input type="radio"/> | Yes | <input type="radio"/> | No | | | | |
| Days per week: | <input type="radio"/> | <3 | <input type="radio"/> | 3-5 | <input type="radio"/> | >5 | | |
| Time/Duration: | <input type="radio"/> | <15 min | <input type="radio"/> | 15-30 min | <input type="radio"/> | 30-45 min | <input type="radio"/> | >45 min |
| Exertion: | <input type="radio"/> | Light | <input type="radio"/> | Mild | <input type="radio"/> | Heavy | | |

If **over 30 years** old, have you had your cholesterol checked in the past 5 years?

- | | | | | | |
|-----------------------|-----|-----------------------|-----|-----------------------|----|
| <input type="radio"/> | N/A | <input type="radio"/> | Yes | <input type="radio"/> | No |
|-----------------------|-----|-----------------------|-----|-----------------------|----|

Does your house have a working smoke detector? Yes No

Do you have firearms in the house? Yes No

How many sexual partners have you had in the past 12 months? _____ Lifetime? _____

When is the last time you had a dental checkup? _____

Review of Systems: Are you experiencing any of these issues now?

Constitutional

Fatigue	<input type="radio"/>	Yes	<input type="radio"/>	No	Fever	<input type="radio"/>	Yes	<input type="radio"/>	No
Weight change	<input type="radio"/>	Yes	<input type="radio"/>	No					

Neurological

Headaches	<input type="radio"/>	Yes	<input type="radio"/>	No	Numbness/Tingling	<input type="radio"/>	Yes	<input type="radio"/>	No
Weakness	<input type="radio"/>	Yes	<input type="radio"/>	No	Seizures	<input type="radio"/>	Yes	<input type="radio"/>	No
Dizziness	<input type="radio"/>	Yes	<input type="radio"/>	No					

ENT

Vision Changes	<input type="radio"/>	Yes	<input type="radio"/>	No	Hearing Changes	<input type="radio"/>	Yes	<input type="radio"/>	No
Sinus Problems	<input type="radio"/>	Yes	<input type="radio"/>	No	Sore Throat	<input type="radio"/>	Yes	<input type="radio"/>	No
Swallowing Problems	<input type="radio"/>	Yes	<input type="radio"/>	No					

Respiratory

Shortness of Breath	<input type="radio"/>	Yes	<input type="radio"/>	No	Wheezing/Asthma	<input type="radio"/>	Yes	<input type="radio"/>	No
Chronic Coughing	<input type="radio"/>	Yes	<input type="radio"/>	No					

Cardiovascular

Chest Pain	<input type="radio"/>	Yes	<input type="radio"/>	No	Irregular Heartbeat	<input type="radio"/>	Yes	<input type="radio"/>	No
High Blood Pressure	<input type="radio"/>	Yes	<input type="radio"/>	No	Leg/Ankle Swelling	<input type="radio"/>	Yes	<input type="radio"/>	No
Fainting	<input type="radio"/>	Yes	<input type="radio"/>	No					

Musculoskeletal

Joint Pain/Stiffness	<input type="radio"/>	Yes	<input type="radio"/>	No	Joint Swelling	<input type="radio"/>	Yes	<input type="radio"/>	No
Back Pain	<input type="radio"/>	Yes	<input type="radio"/>	No	Neck Pain	<input type="radio"/>	Yes	<input type="radio"/>	No

Gastrointestinal

Nausea/Vomiting	<input type="radio"/>	Yes	<input type="radio"/>	No	Stomach Ulcer	<input type="radio"/>	Yes	<input type="radio"/>	No
Diarrhea	<input type="radio"/>	Yes	<input type="radio"/>	No	Constipation	<input type="radio"/>	Yes	<input type="radio"/>	No
Blood in Stool	<input type="radio"/>	Yes	<input type="radio"/>	No					

Skin

Rashes	<input type="radio"/>	Yes	<input type="radio"/>	No	Skin Cancer	<input type="radio"/>	Yes	<input type="radio"/>	No
Itching/Burning	<input type="radio"/>	Yes	<input type="radio"/>	No	Concerning Moles	<input type="radio"/>	Yes	<input type="radio"/>	No

Hematologic

Anemia	<input type="radio"/>	Yes	<input type="radio"/>	No	Easy Bruising	<input type="radio"/>	Yes	<input type="radio"/>	No
Bleeding Problem	<input type="radio"/>	Yes	<input type="radio"/>	No					

Endocrine

Excessive Thirst	<input type="radio"/>	Yes	<input type="radio"/>	No	Heat/Cold Intolerance	<input type="radio"/>	Yes	<input type="radio"/>	No
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Urinary

Pain with Urination	<input type="radio"/>	Yes	<input type="radio"/>	No	Frequent Night Urination	<input type="radio"/>	Yes	<input type="radio"/>	No
Frequent Urination	<input type="radio"/>	Yes	<input type="radio"/>	No	Incontinence	<input type="radio"/>	Yes	<input type="radio"/>	No
Difficulty with strength or flow rate in urine stream	<input type="radio"/>	Yes	<input type="radio"/>	No	Difficulty starting urinary stream	<input type="radio"/>	Yes	<input type="radio"/>	No

Psychological

Depressed or Mood Swings	<input type="radio"/>	Yes	<input type="radio"/>	No	Diminished Energy	<input type="radio"/>	Yes	<input type="radio"/>	No
Sleep Disturbance	<input type="radio"/>	Yes	<input type="radio"/>	No	Little interest in surroundings	<input type="radio"/>	Yes	<input type="radio"/>	No
Anxiety	<input type="radio"/>	Yes	<input type="radio"/>	No					

Gynecologic

Breast pain	<input type="radio"/>	Yes	<input type="radio"/>	No	Vaginal Discharge	<input type="radio"/>	Yes	<input type="radio"/>	No
Pain with intercourse	<input type="radio"/>	Yes	<input type="radio"/>	No					

Other

Sexually Transmitted Diseases	<input type="radio"/>	Yes	<input type="radio"/>	No	Sexual Problems	<input type="radio"/>	Yes	<input type="radio"/>	No
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(getting and keeping erections, completing intercourse, etc)

Patient Signature _____ **Date** _____