

Tiffany Gorman, MD • Christian Fulmer, DO

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. What are you being seen for today? _____

Medical History

Diabetes	<input type="radio"/>	Yes	<input type="radio"/>	No	Ovarian Cancer	<input type="radio"/>	Yes	<input type="radio"/>	No
Stroke	<input type="radio"/>	Yes	<input type="radio"/>	No	Prostate Cancer	<input type="radio"/>	Yes	<input type="radio"/>	No
Arthritis	<input type="radio"/>	Yes	<input type="radio"/>	No	High Blood Pressure	<input type="radio"/>	Yes	<input type="radio"/>	No
Osteoporosis	<input type="radio"/>	Yes	<input type="radio"/>	No	High Cholesterol	<input type="radio"/>	Yes	<input type="radio"/>	No
Colon Cancer	<input type="radio"/>	Yes	<input type="radio"/>	No	Heart Attack/Heart Disease	<input type="radio"/>	Yes	<input type="radio"/>	No
Breast Cancer	<input type="radio"/>	Yes	<input type="radio"/>	No	Skin Cancer	<input type="radio"/>	Yes	<input type="radio"/>	No

Other Medical problems:

Allergies

Are you allergic to any medications? Yes No If yes, please list: _____

Are you allergic to food or environmental substances? Yes No If yes, please list: _____

Social History

Do you smoke cigarettes? Yes No

Have you ever smoked cigarettes in the past? Yes No

If yes, when did you quit? _____

How long have you smoked? >1 year 1-10 years 10+ years

How many packs per day? >1 pack 1-2 packs 3+ packs

When are you planning to quit? Now Next 6 Months Sometime Never

Do you drink alcohol regularly? Yes No

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

Have you ever had a blood transfusion? Yes No

Do you participate in sports/recreational activities? Yes No

If yes, please list _____.

Where were you born? _____

Have you lived in any other countries? Yes No

If Yes, Where? _____

Are you married or in a monogamous relationship? Yes No

Do you observe "Safe Sex" practices 100% of the time? Yes No

Any toxin exposures at work or home? Yes No

Other Physicians that you see: _____ Physicians Name: _____ Specialty: _____

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** _____

Diabetes Stroke Osteoporosis High Blood Pressure

Arthritis Colon Cancer Breast Cancer Ovarian Cancer

Prostate Cancer Skin Cancer High Cholesterol Heart Attack/Disease

Other _____

Immunizations:

Tetanus in last 10 years Yes No
Pneumonia Yes No
Hepatitis A Yes No
Hepatitis B Yes No
Chicken Pox Yes No
 Have you had chicken pox? Yes No
Influenza Yes No
HPV vaccine Yes No

Date(s):

Prevention:**Exercise:**

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

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

Fatigue Yes No
Weight change Yes No
Fever Yes No

Neurological

Headaches Yes No Numbness/Tingling Yes No
Weakness Yes No Seizures Yes No
Dizziness Yes No

ENT

Vision Changes Yes No Hearing Changes Yes No
Sinus Problems Yes No Sore Throat Yes No
Swallowing Problems Yes No

Respiratory

Shortness of Breath Yes No Wheezing/Asthma Yes No
Chronic Coughing Yes No

Cardiovascular

Chest Pain Yes No Irregular Heartbeat Yes No
High Blood Pressure Yes No Leg/Ankle Swelling Yes No
Fainting Yes No

Musculoskeletal

Joint Pain/Stiffness Yes No Joint Swelling Yes No
Back Pain Yes No Neck Pain Yes 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 Urination	<input type="radio"/>	Yes	<input type="radio"/>	No
Frequent Urination at night	<input type="radio"/>	Yes	<input type="radio"/>	No	Incontinence	<input type="radio"/>	Yes	<input type="radio"/>	No
Difficulty starting urinary stream	<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

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 (getting and keeping erections, completing intercourse, etc)	<input type="radio"/>	Yes	<input type="radio"/>	No
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Medications (Please list name of medication and dosage)	
Hospitalization (Please list)	Surgeries (Please list surgery type and year)

Patient Signature _____

Date _____