PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
IF SOMETHING DOES NOT APPLY, PLEASE STATE "NA" DO NOT LEAVE BLANK

Patient Name:_____ Date of Birth:_____

Reason for today's visit: _____

Patient's Past Medical History - ☑ All that apply

(If NONE of the list applies to you, please ☑ "No Pertinent Past Medical History")

	Details
☐ **No Pertinent Past Medical History**	
☐ Asthma	
☐ Bleeding Disorder/Clotting	
☐ Breast Cancer	
☐ Cancer	
☐ Cardiac Stents	
☐ Chest Pain / Tightness	
☐ Diabetes	
☐ Heart Disease	
☐ Heart Murmur	
☐ Hepatitis	
☐ High Blood Pressure	
☐ Other	
☐ Skin Disease	
☐ Stroke	
☐ Thyroid Disorder	
☐ Tuberculosis	
☐ Ulcers	

Does the patient have any of the following?

☐ **Pacemaker** ☐ **Defibrillator** ☐ **Hip Replacement**
☐ **Knee Replacement** ☐ **Shoulder Replacement** ☐ **DOES NOT APPLY TO ME**

Skin History (Please Check What Applies)

☐ **NO SIGNIFICANT HISTORY** ☐ **Actinic Keratosis** ☐ **Basal Cell Carcinoma**
☐ **Eczema** ☐ **Malignant Melanoma** ☐ **Other Suspicious Lesion**
☐ **Psoriasis** ☐ **Squamous Cell Carcinoma** ☐ **Urticaria**

THIS FORM IS FRONT & BACK

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Past Surgeries: (*If none, please state NONE)*

Surgery/Hospitalization	Date	Physician	Anesthesia Complications?	Notes

Patient's Family History:

PLEASE ONLY STATE: *Mother, Father, Brother, Sister & Children*

Condition	Afflicted Family Member
☐ **No Relevant Family History**	
☐ Unknown – Adopted	
☐ Abnormal Bleeding	
☐ Abnormal Clotting	
☐ Breast Cancer	
☐ Cancer	
☐ Diabetes	
☐ High Blood Pressure	
☐ Premature Coronary Heart Disease	
☐ Von Willebrand	

Allergies: (*if none, please state NONE)*

Allergy	Reaction

Pneumonia Vaccine [Measure #111 (NQF 0043)]

Offers Vaccine
Does not Offer Vaccine

☐ **Pneumococcal Vaccine Previously Received**
☐ **Pneumococcal Vaccine was not administered, or previously received, reason not otherwise specified.**

THIS FORM IS FRONT & BACK

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
IF SOMETHING DOES NOT APPLY, PLEASE STATE "NA" DO NOT LEAVE BLANK

Current Oral & Topical Medications: (*If none, please state NONE)*

Medication	Dosage	Taken How Often	Route Taken (Oral, Topical, Injection?)	Prescribing Doctor

Patient's Social History: (Must choose at least **one** answer in each category)

Alcohol Use

☐ Denies alcohol use
☐ Alcohol use socially
☐ Alcohol use daily
☐ History of alcoholism

Recreational Drug Use

☐ Denies drug use
☐ Admits drug use
☐ History of drug abuse

Smoking Status

☐ Daily smoker - **Year Started: _____**
☐ Some day smoker – **Year Started: _____**
☐ Former Smoker:
Year Started: _____
Year Quit: _____
☐ Never Smoked

Female Questions:

Age of first period? _____
Number of pregnancies? _____
Number of children? _____

Have you ever breast fed? _____
Date of last mammogram? _____

Height: _____ inches **Weight: _____ pounds**

Height Guide:

4' = 48 in	**5' 6" = 66 in**
4'6" = 54 in	**6' = 72 in**
5' = 60 in	**6'6" = 78 in**

_____
Print Name of Patient

_____ _____
Signature of Patient/Legal Guardian Date