NORTHSIDE HOSPITAL

Northside Family Medicine & Urgent Care

Name:	Date:
Date of Birth:	Spouse/Significant Other:
☐ Male ☐ Female	Marital Status:
Birthplace:	# of Children: Ages:
Ethnicity:	Pets (outside)
Religion	Pets (inside)
Occupation:	Recent/Frequent Travel Destinations:
Education:	

Reason you are being seen today:_____

_____

Please list your current medications and dosages: _____

_____

_____

_____

Please list any allergies (with Reaction) you may have:_____

_____

Please Update Smoking Status: Select One

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoked
- ☐ Smoker
- ☐ Current status unknown
- ☐ Unknown if every smoked

ADULT HISTORY AND REVIEW OF SYSTEMS QUESTIONNAIRE

PAST MEDICAL PROBLEMS: (Have you ever had?)

Yes	No		Yes	No		Yes	No	
		Cancer Type:_____			Pneumonia			Depression
		Heart Attack/Coronary			Tuberculosis			Head Injury
		Artery Disease			Positive TB Skin Test			Broken Bones
		Rheumatic Fever			Osteoporosis			Blood Transfusions
		Heart Failure			Arthritis			Sexually Transmitted Diseases:
		High blood pressure			Gout			Herpes
		High cholesterol			Frequent Bladder Infection			HIV
		Stroke			Kidney Stones			Gonorrhea
		Diabetes			Kidney Disease			Chlamydia
		Gallstones			Pollo			Syphilis
		Liver Disease			Chicken Pox			Intravenous Drug Abuse
		Hepatitis/Jaundice			Infectious Mono			Needle Injury
		Ulcer Disease			Anemia			Mumps
		Heartburn/Reflux			Frequent Sinus Infections			Migraines
		Asthma			Glaucoma			Prostate Enlargement
		Seizures			Thyroid Trouble			Cystic Fibrosis
		Emphysema			Hives			Malaria
		Other:						

PAST SURGICAL HISTORY

Yes	No		Year	Yes	No		Year	Yes	No		Year
		Eyes (Laser or Vision corrected)				Appendix				Spinal Surgery/Back	
		Eyes (Cataract/Glaucoma)				Intestine/Colon				Orthopedic:	
		Ears				Hemorrhoids				Hips/Knees	
		Sinus/Nasal Septum				Hernia				Shoulder	
		Tonsils/Adenoid				Breast				Feet/Hands	
		Thyroid				Uterus/Hysterectomy				C-Section	
		Heart				Ovaries					
		Stomach				Spinal Surgery/Neck					
		Varicose Veins				Prostate				Vasectomy	
		Gall Bladder								Tubal Ligation	
Other/Year:											

ADULT HISTORY AND REVIEW OF SYSTEMS QUESTIONNAIRE

Do you CURRENTLY have?

Yes	No	GENERAL
		Fatigue
		Night Sweats
		Fever
		Weight Gain>10 pounds
		Weight Loss<10 pounds
		SKIN
		Nail Changes
		New Lesions
		Rash
		Skin Color Changes
		HE/ENT
		Double Vision
		Eye Pain
		Eye Redness
		Decreased Hearing
		Earache
		Ear Ringing
		Nose Bleeds
		Dry Mouth
		Hoarseness
		Oral Ulcers
		Sore Throat
		NECK
		Neck Pain
		Swollen Glands
		RESPIRATORY
		Chronic Cough
		Decreased Exercise Tolerance
		Difficulty Breathing
		Coughing Up Blood
		Sputum Production
		Wheezing
		BREAST
		Breast Mass
		Breast Pain
		Nipple Discharge
		Skin Changes

Yes	No	CARDIOVASCULAR
		Chest Pain
		Leg Pains w/walking
		Leg Swelling
		Night Awakening due to trouble Breathing
		Palpitations
		Shortness of Breath
		GASTROINTESTINAL
		Abdominal Pain
		Change in Bowel Habits
		Constipation
		Diarrhea
		Nausea
		Vomiting
		Rectal Bleeding
		Trouble Swallowing
		Reflux/Heartburn
		GENITOURINARY
		Vaginal Discharge
		Menstrual Irregularities
		Difficulty Starting/Stopping Urinary Stream
		Painful Urination
		Change in Urinary Stream
		Increased Frequency
		Blood in Urine
		Loss of Bladder Control
		Nighttime Urination
		Urinary Retention
		Urethral Discharge
		Problems Maintaining an Erection
		Penile Lesions
		Testicular Mass
		Testicular Pain

Yes	No	MUSCULOSKELETAL
		Decreased Range of Motion
		Joint Pain
		Joint Redness
		Joint Swelling
		Joint Stiffness
		Muscle Wasting
		Muscle Weakness
		Muscle Aches/Pains
		Morning Stiffness *How Long?*_____
		NEUROLOGICAL
		Loss of Bowel Control
		Dizziness/Vertigo
		Headaches
		Numbness/Tingling
		Passing Out
		Seizures
		Tremor
		Memory Problems
		ENDOCRINE
		Appetite Changes
		Cold Intolerance
		Increased Thirst
		Increased Urination
		Hair Changes
		Sexual Dysfunction
		HEMATOLOGY
		Easy Bruising
		Enlarged Lymph Nodes
		Prolonged Bleeding

Yes	No	PSYCHIATRIC
		Anxiety
		Change in Sleep Pattern
		Depression
		Hallucinations
		Suicidal Thoughts
		Do you feel safe at home?
		Have you ever felt you should cut down your drinking?
		Have people annoyed you by criticizing your drinking?
		Have you ever felt guilty about drinking?
		Have you ever needed a drink first thing in the morning?
		INFECTIOUS DISEASE
		Exposure to TB
		Exposure to HIV
		Exposure to Hepatitis
		Exposure to STD's

HAS ANYONE IN YOUR FAMILY EVER HAD? IF YES Check box and list relationship.

	Relationship		Relationship		Relationship
☐ Cancer & Type		☐ Dialysis		☐ Crohn's/Colitis	
☐ Diabetes		☐ Chronic Lung Disease		☐ Alzheimer's	
☐ Cardia Dysrhymthia		☐ Tuberculosis		☐ Alcoholism	
☐ Congestive Heart Failure		☐ Rheumatoid Arthritis		☐ Bleeding Tendency	
☐ Coronary Artery Disease		☐ Thyroid Trouble		☐ Anemia	
☐ Valvular Heart Disease		☐ Osteoporosis		☐ Gout	
☐ High Blood Pressure		☐ Cystic Fibrosis		☐ Depression	
☐ High Cholesterol		☐ Asthma		☐ Mental Illness	
☐ Stroke		☐ Peptic Ulcer		☐ Seizures	
☐ Kidney Stones		☐ Gallstones		☐ Migraine Headaches	
☐ Kidney Disease					
☐ OTHER					

GYNECOLOGICAL/OBSTETRICAL HISTORY:

Are you having a GYN exam as part of your visit today? _____

Name of OB/GYN _____

Age when you Started Menstruating? _____ Number of Pregnancies? _____

Date of Last PAP? _____ Number of Births? _____

History of abnormal PAP'S Yes / No *(Please circle one)* Vaginal / C-Section *(Please circle one)*

Date of Last Mammogram? _____ History of Abnormal Mammogram? Yes / No *(Please circle one)*

Method of Contraception _____

Menstrual Cycles? Regular / Irregular *(Please circle one)*

Pain with Periods? Yes / No *(Please circle one)*

Age at Menopause? _____

VACCINATION HISTORY: Please provide approximate date if know.

_____Flu _____Whooping Cough (Pertussis)

_____Pneumonia (Pneumovax) _____Tetanus/diphtheria

_____Shingles (Zostavax((Age>50) _____MMR (measles, mumps, rubella)

_____HPV (Gardail) (Ages 11-26) _____Chicken Pox (Varivax)

_____Hepatitis B _____Meningitis