Atlantic Medical Physicians

Patient Name: _____

DOB:_____ **Date:** _____

Reason for today's visit: _____

_____

List all current medications and dosages:

Medication	Dose/Frequency	Medication	Dose/Frequency

Are you allergic to any drugs? *Circle one* Yes or No *If yes, please list those drugs below:*

Drug	Reaction (i.e. rash, hives)	Drug	Reaction (i.e. rash, hives)

Hospitalizations: _____

_____

Surgeries: _____

_____

Are you Pregnant? **YES**_____ **NO**_____

When was your last:

Tetanus _____/_____/ _____

PAP Smear _____/_____/ _____

Mammography_____/_____/ _____

Colonoscopy _____/_____/ _____

Blood Test _____/_____/ _____

EKG _____/_____/ _____

Chest X-ray _____/_____/ _____

Past Medical History *(Please **circle** all that apply to you):*

Diabetes	Heart Disease	High Blood Pressure	Heart Attack
High Cholesterol	Asthma	Stomach Ulcers	Kidney Disease
Liver Disease	Lyme Disease	Rheumatoid Arthritis	Cancer
Depression	Anxiety	Emphysema	COPD
Hepatitis	Seizures	Thyroid Disease	Coronary Artery Disease
Mulitple Sclerosis	Bleeding Disorder	Congestive Heart Failure	Vascular Disease
Lupus	Tuberculosis	Weight loss/gain	Gallbladder Disease
Skin Disease	Venereal Disease	Anemia	Osteoporosis

Please list any medical conditions you may have not mentioned above:

_____

_____

_____

Family History *(Please **check** all that apply to members of your family):*

	Mother	**Father**	**Sibling**	**Children**	**Granparent**
High Blood Pressure					
Diabetes					
Bleeding Disorder					
Stroke					
Heart Disease/Attacks					
Lung Disease					
Kidney Disease					
Mental Disorder					

Please list any medical disease that a member of your family may have that is not mentioned above:_____

Social History

Please **circle** one: Single / Married / Partnered / Widowed / Divorced

- **Do you smoke?**____Current Smoker ___Former Smoker ___Never Smoked

  ___Pipe Smoke_____Cigar Smoker ___Smoker, current status unknown ___Unknown

  If yes, how much do you smoke?____3 cigarettes or less per day ___Half a pack/day
  ___More than a pack per day

- **Do you drink alcohol?** YES NO

  If yes, how frequent?____Social only ___Several times per week ___Everyday

- **Do you or have you used illicit drugs?** YES NO

  If yes, what kind?____IV Drugs ___Pills ___Marijuana

Occupation: _____

Review of Systems

Please circle any of the following symptoms that you've experienced recently:

Constitutional

Fatigue	Fever	Night Pain	Weight loss	Weight gain

Eyes

Vision loss	Red eyes	Glasses/Contacts	Dry eyes	Blurry vision

Ears/Nose/Mouth

Sore throat	Hearing loss	Cough	Dry mouth	Nose bleed

Cardiovascular

Chest pain	Palpitations	Leg swelling	Dizziness	SOB

Respiratory

Chronic cough	Wheezing	Chest pain	Shortness of Breath (SOB)

Gastrointestinal

Heartburn	Nausea	Abdominal pain	Diarrhea	Blood in stool

Genitourinary

Burn w/urination	Urine incontin	Freq urination	Blood in urine	UTI's

Skin

Rash	Hives	Alopecia	Raynaud's	Infection

Neurological

Headache	Weekness	Dizziness	Tremor	Seizures

Psychiatric

Depression	Eating disorder	Suicidal	Panic attacks	Trouble sleeping

Endocrine

Excess sweating	Excess thirst	Freq urination	Heat intolerance	Fatigue

Hematological/Lymph

Easy bleeding	Easy bruising	Swollen glands	Night sweats	Fevers

Allergy/immune

Sinus congestion	Itchy eyes	Runny nose	Scratchy throat	Ear fullness

Patient Signature:_____ Date: _____