Total Med SOLUTIONS

PATIENT INFORMATION:

Name: _____

Address: _____Apt#_____

City: _____State: ____ Zip: _____

Sex: _____ Date of Birth: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____
(Used for newsletters, online consults, medication refills)

How did you hear about us?:_____

PREFERED CONTACT METHOD:

Cell Home Phone Work Phone Email

Preferred Language: _____

Employer: _____

Drivers License #: _____
(Used for test results and orders)

Marital Status: Married, Single, Divorced, Other

Emergency Contact: _____

Phone number: _____

Relationship: _____

LIST OF CURRENT MEDICATIONS:

MEDICATION	MG/DOSE	FREQUENCY

Drug Allergies(INCLUDE REACTION)

_____

Non-drug Allergies(INCLUDE REACTION)

_____

SOCIAL HISTORY:

Tobacco Use: YES/NO – Type:_____

Alcohol Use: YES/NO - How Often:_____

Exercise: YES/NO - How Often:_____

ROUTINE HEALTH SCREENINGS:

(Most recent Dates)

Colonoscopy: _____

Mammogram: _____

Pap Smear:_____

Bone Density_____

Tetanus Booster:_____

Last Menstrual Period: _____

Method of Birth Control:_____

Medical/Surgical HX:_____

MEDICAL HISTORY (check all that apply and include date)

	YES	DATE		YES	DATE		YES	DATE
AIDS/HIV			Gout			Peptic Ulcer		
Anemia			Heart Abnormalities (specify)			Pneumonia		
Anxiety			Heart Attack			Psychiatric Problems		
Arthritis			Hemorrhoids			Pulmonary Fibrosis		
Asthma			Hepatitis			Rheumatoid Arthritis		
Back Problems			Hernia (specify)			Seizures		
Bleeding Disorder/ Blood Clots			High Cholesterol			Skin Disease		
Bladder Infection			Hypertension			Sexually Transmitted Disease		
Cancer (Breast, Colon, Lung, Skin, Prostate)			Hyperthyroid			Sleep Apnea		
Cataract			Hypothyroid			Stroke		
Colitis			Kidney Stones			Other:		
Congestive Heart Failure			Liver Disease					
Coronary Heart Disease			Lymphoma					
COPD			Lupus					
Depression			Migraines					
Diabetes			Multiple Sclerosis					
Erythematosus			Osteoarthritis					
Gallstones			Osteoporosis/ Osteopenia					
GERD			Palpitation					
Glaucoma			Pancreatitis					