BLUE RIDGE HEALTH CARE

Name: _____ **Date:** _____ **DOB:** _____

☐ NO ☐YES HAVE YOU HAD ANY HOSPITALIZATIONS/ SURGERIES/ ILLNESSES **IN THE PAST YEAR**? (IF YES, EXPLAIN IN SPACE BELOW)

ALLERGIES ☐ None ☐ Latex ☐ Codeine ☐ Morphine ☐ Penicillin ☐ Sulfa ☐ Iodine ☐ Aspirin ☐ Foods ☐ Bee Stings ☐ OTHER

MEDICATIONS: Please bring all medication bottles with you to your visit. This includes all OTC medications

PREVIOUS SURGERIES or PROCEDURES **(indicate approximate date)**

☐ Appendectomy	☐ Laparoscopy	☐ Obesity Surgery (gastric bypass)
☐ Colonoscopy _____(yr)	☐ Tubal ligation	☐ Lithotripsy (kidney stone)
☐ Gallbladder	☐ Hysteroscopy	☐ Orthopedic surgery (Back, knee, hip, etc)
☐ Tonsillectomy	☐ Endometrial ablation	☐ Thyroid surgery
☐ Dental	☐ Hysterectomy, partial or total	☐ Sinus surgery
☐ Breast	☐ Ovaries- removal of one or both ovaries	☐ Heart Surgery
☐ Cosmetic surgery	☐ Urethral stretching	☐ Hernia repair
☐ D & C	☐ Bladder surgery	☐ Hemorrhoid surgery

LIST ALL OTHER SURGERIES OR HOSPITALIZATIONS

MEDICAL HISTORY (indicate whether you have had any of the following medical problems **with approximate date of diagnosis**)

☐ Anemia	☐ Colon polyps	☐ Heart Attack	☐ Rheumatoid Arthritis
☐ Anesthesia problems	☐ Crohn's Disease	☐ Heart Murmur	☐ Reflux (GERD)
☐ Anxiety Disorder	☐ Celiac Disease	☐ Hearing problems	☐ Sleep Apnea
☐ Asthma	☐ Depression requiring counseling or medication	☐ Hepatitis (A, B, C, other)	☐ Schizophrenia
☐ Attention Deficit Disorder	☐ Depression, postpartum	☐ High Cholesterol	☐ Skin Disorder
☐ Allergies	☐ Diabetes	☐ High blood pressure	☐ Stroke
☐ Bipolar Disorder	☐ Epilepsy (seizures)	☐ Irritable Bowel Syndrome	☐ Stomach Ulcer
☐ Blood Clot in legs/lungs	☐ Glaucoma	☐ Kidney Disease	☐ Thyroid Disorder
☐ Blood Transfusion	☐ Headaches, chronic	☐ Kidney Stones	☐ Tuberculosis
☐ Cancer of any type	☐ Headaches , migraine	☐ Lupus	☐ Varicose Veins
☐ Chemical dependence or substance abuse		☐ Mitral valve prolapse	☐ Weight Problems – Obesity
☐ Chronic Pain requiring treatment		☐ Osteoarthritis	☐
☐ Chronic Fatigue Syndrome		☐ Osteoporosis	

Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed

FAMILY HISTORY ☐ **I was adopted** ☐ **I do not know my family history**

	Mother	Father	Child(ren)	Sister(s)	Brother(s)	Aunt/Uncle	Grandparents
Breast cancer	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Ovarian cancer	☐	☐	☐	☐	☐	☐	☐
Uterine cancer	☐	☐	☐	☐	☐	☐	☐
Cervical cancer	☐	☐	☐	☐	☐	☐	☐
Cancer, other	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐
Genetic disease	☐	☐	☐	☐	☐	☐	☐

OTHER PERTINENT FAMILY HISTORY: _____

Alcohol Use	☐ Never used	☐ I quit using alcohol	☐ Social drinker	☐ Less than 2 days/week	☐ Daily
Tobacco Use	☐ I have never used tobacco products	☐ I quit using tobacco products	☐ I use tobacco products	☐**I would like to quit smoking**	
Illicit Drug Use	☐ I have never used illicit drugs	☐ I quit using illicit drugs	☐ I use illicit drugs	☐ I have used IV/ injection drugs	☐ I have or have had a drug problem
Education	Are you a student? ☐ Middle school ☐ High School ☐ College	☐ High school graduate	☐ GED	☐ College graduate	☐Master's degree or higher
Occupation	☐ Employed, full time	☐Employed, part time	☐ Unemployed	☐ Disabled	☐ Retired

REVIEW OF SYSTEMS Please check any of the SYMPTOMS below that you are currently experiencing or have experienced**.**

Y/N	Y/N	Y/N	Y/N	Y/N
☐☐ Fever	☐☐ Weight loss			
☐☐ Vision problems	☐☐ Blurred vision	☐☐ Hearing problems	☐☐ Nose bleeds	☐☐ Ringing in ears
☐☐ Rashes	☐☐ Changes in skin moles	☐☐ Unusual hair growth or hair loss		
☐☐ Breast lumps	☐☐ Breast pain	☐☐ Discharge from nipples		
☐☐ Chest pain	☐☐ Palpitations/ irregular heart rate	☐☐ Ankle swelling	☐☐ Heart murmur as an adult	☐☐ Coughing up blood
☐☐ Shortness of breath		☐ Chronic cough		
☐☐ Abdominal pain- upper	☐☐ Abdominal pain - lower	☐☐ Bloody or black tarry stool	☐☐ Diarrhea	☐☐ Constipation
☐☐ Nausea/Vomiting	☐☐Bloating	☐☐ Flatulence/gas	☐☐Changes in Appetite	☐☐ Heartburn
☐☐ Urinary frequency	☐☐ Urinary urgency	☐☐ Painful urination	☐☐ Bloody urine	☐☐ Urine leakage
☐☐ Difficulty starting urination		☐☐ Getting up frequently at night to urinate		
☐☐ Muscle aches	☐☐ Joint aches	☐☐ Back pain	☐☐ Stiffness	
☐☐ Headaches	☐☐ Seizures	☐☐ Blackouts or fainting spells	☐☐ Memory disturbance	☐☐ Numbness in extremities
☐☐ Cold intolerance	☐☐ Heat Intolerance	☐☐ Excessive thirst	☐☐ Hair /loss	☐☐ Hot flashes
	☐☐Night sweats		☐☐ Excessive sweating	
☐☐ Anxiety/ panic	☐☐ Depression	☐☐ Inability to concentrate	☐☐ Suicidal thoughts	
☐☐ Easy bruising	☐☐ Prolonged bleeding	☐☐ Swollen glands		

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____