Dear Patient: Southview is now using an **Electronic Medical Record** system.
Please help us by filling out this form to the best of your knowledge.

NAME: _____ **BIRTHDATE**_____

ADDRESS: _____ **EMAIL:**_____

PHONE: *HOME* ( ) _____ *WORK*: ( ) _____ *CELL*: ( ) _____

LOCAL PHARMACY NAME/ADDRESS: _____

PHARMACY PHONE # ( ) _____ FAX#( )_____

MAIL ORDER PHARMACY NAME/CITY/STATE: _____

PLEASE CIRCLE ANY ILLINESS YOU HAVE HAD:

Anxiety	Gonorrhea	Jaundice	Osteoporosis
Asthma	Gout	Kidney Disease	Rheumatic Fever
Bleeding Tendency	Heart Disease	Kidney Stones	Rheumatoid Arthritis
Cholesterol High or Low	Heart Failure	Liver Disease	Seizures
Degenerative Arthritis	Hepatitis/ **Type**____	Lung Disease	Syphilis
Depression	High Blood Pressure	Migraine Headache	Tuberculosis
Glaucoma	HIV/AIDS	Neuropathy	Vein Trouble

DIABETES (if yes, how long & **TYPE**) _____ CANCER (if yes, where) _____

OTHER ILLINESSES: _____

PREVIOUS **SURGERY**/INJURIES (date and physician):_____

DRUG **ALLERGIES** (also list reactions):_____

FAMILY HISTORY:

Father: Alive? Y or N Illnesses: _____Age at death_____ Cause_____

Mother: Alive? Y or N Illnesses: _____Age at death_____ Cause_____

Brother/Sister-Health Issues: _____

Son/Daughter-Health Issues: _____

Other Relatives Health Issues: _____

SOCIAL HISTORY: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Living with: _____

Smoking: Y or N Packs a day____ How long ____ Circle Type: (pipe, cigar, cigarettes, chew)
Recently quit _____ Wants to quit_____

Alcohol: Y or N Drinks/day average_____ Circle Type: (beer, wine, liquor)

Substance abuse: Y or N List type of drug used: _____

Occupation: _____ **Religion**: _____

Caffeine: Y or N Drinks/day average_____ Circle Type: (tea, coffee, sodas, medicine, foods)

Hobbies: _____

Diet: Y or N If yes, Circle Method of Diet: Low Carb, Low Calorie, Low Fat, Vegetarian, Other:_____

Exercise: Y or N Frequency _____ Duration _____ Type ____ _____

MEDICATIONS: NAME/DOSE/HOW IT'S TAKEN

1. _____
2. _____
3. _____
4. _____
5. _____

NAME/DOSE/HOW IT'S TAKEN

6. _____
7. _____
8. _____
9. _____
10. _____

HEALTH MAINTENANCE: (enter date of your last exam/study)

Assisted Device: (Please circle one) None Walker Manual Scooter Power Scooter Manual Wheelchair Power Wheelchair

BONE DENSITY: Date_____ Findings:_____ Performed by_____

Colonoscopy: Date_____ Findings: _____ Performed by_____

Eye Exam: Date_____ Findings:_____ Performed by_____

Diabetic Foot Exam: Date_____ Findings:_____ Performed by_____

Mammogram: Date_____ Findings:_____ Performed by_____

OBGYN Care: Date_____ Findings:_____ Performed by_____

PSA: Date_____ Findings:_____ Performed by_____

Other Physicians seeing you currently: _____ _____

HOSPITALIZATIONS THIS YEAR (list reason/date):_____

IMMUNIZATIONS AND DATES:

Gardisil_____ Hepatitis B_____ Influenza_____ Pneumovax_____ Measles_____

Meningococcal_____ Rubella_____ Tetanus_____ Zostavax_____

CONSTITUTIONAL: ☐ fevers/chills ☐ night-sweats ☐ anorexia ☐ weight loss

EYES: ☐ Blurry vision

EARS, NOSE, MOUTH & THROAT: ☐ decreased hearing ☐ runny nose ☐ mouth sores ☐ sore throat

CARDIOVASCULAR: ☐ chest pain ☐ palpitations ☐ decreased exercise tolerance

RESPIRATORY: ☐ cough ☐ shortness of breath

GASTROINTESTINAL: ☐ nausea/vomiting ☐ difficulty swallowing ☐ heartburn ☐ diarrhea
☐ Constipation ☐ blood in stool ☐ hemorrhoid problems ☐ abdominal pain

MUSCULOSKELETAL: ☐ joint pain/swelling ☐ weakness

DERMATOLOGIC: ☐ rashes ☐ jaundice

NEROLOGIC: ☐ numbness/tingling ☐ difficulty speaking ☐ difficulty walking
☐ decreased sensation ☐ weakness

PSYCHIATRIC: ☐ depression ☐ anxiety ☐ difficulty sleeping

HEMATOLOGIC: ☐ anemia ☐ easy bruising

Signature: _____ Date: ____/____/____

Physician: _____ Date: ____/____/____