

Patient Name: _____ Date of Birth: _____

Today's reason for being seen: _____

Check Any Of The Following Symptoms You Have Had Recently:

- | | | | |
|-----------------|---|--|---|
| Const: | <input type="checkbox"/> Fever | <input type="checkbox"/> Chills | <input type="checkbox"/> Unexpected weight loss |
| Skin: | <input type="checkbox"/> Rash | <input type="checkbox"/> Itching | <input type="checkbox"/> Unusual lesion |
| Neuro: | <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Passing out |
| Psych: | <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Hallucinations |
| Eye: | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Drainage from eyes | <input type="checkbox"/> Recent vision changes |
| EENT: | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Chronic sore throat | <input type="checkbox"/> Nasal Congestion or bleeding |
| Pulmo: | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Wheezes |
| Cardiac: | <input type="checkbox"/> Chest pain/pressure | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Ankle Swelling |
| GI: | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Abdominal Pain |
| GU: | <input type="checkbox"/> Pain when urinating | <input type="checkbox"/> Urgency/frequency of urination | |
| Musculo: | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Muscle/Joint pain (other than reason for visit) | |
| Endo: | <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Excessive thirst or urination | |
| Heme: | <input type="checkbox"/> Bleeding Excessively | <input type="checkbox"/> Bruise Easily | |

NONE of the above applies to me (check box)

List any **medications** you take: _____

List any **allergies** to medicine you have: _____

Year of your last tetanus shot: _____ More than 10 years? _____

Do you have any of the following Medical Problems?

- | | | | |
|-----------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma or lung disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> NONE |

Do any of the following problems run in your Family?

- | | | | |
|-----------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma or lung disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> NONE |

Do you smoke? Yes No Packs per day _____ for _____ years

Do you drink alcohol? Yes No Drinks per week _____

How did you hear about FirstMed? Billboard Yellow Pages Internet Friend TV/Radio ad

- | | | |
|--|--|---|
| <input type="checkbox"/> FirstMed Employee | <input type="checkbox"/> My doctor _____ | <input type="checkbox"/> Pharmacy _____ |
| <input type="checkbox"/> Employer _____ | <input type="checkbox"/> Insurance company _____ | <input type="checkbox"/> Other: _____ |

If you would be willing to answer a few survey questions to assist us in improving our services, please list a phone number where you can be reached: () _____ When is the best time to call? 9am-5pm 5pm-9pm

We would like to send you information about FirstMed services, special offers, etc. If you would like to receive information, please provide your email address. _____

(FirstMed will never share your email address with an outside entity.)

I understand that if I should have any complications, my condition worsens in any way, or if I do not improve in 24 to 48 hours, I will return to be re-examined immediately.

Patient's Signature/Guarantor's Signature

Today's Date