

C SPECIA	ALISTS				DATE:
DEMOGRAPHICS					
Name:				Date	of Birth:
Ethnicity (optional):	Hispanic or Latino	🗌 Not Hispani	ic or Latino		
Race (optional):					
	🗆 Asian Indiar	n 🗆 Ja	panese	Native Hawaiian	
		🗆 Korean		ipino	
)ther Asian (Please state):			•	ce:
Sex: 🗆 Male	🗌 Female				
PREFERRED LANGUAGE					
Is English your prefe	erred Language? 🛛 Yes				
	🗆 No, V	What is your prefe	erred language		
MAIN PROVIDER					
	ian:				
Referring Physician:			Phone Numbe	r:	
Current problem or	roacon for concultation.				
Current problem of	reason for consultation: _				
VACCINATIONS					
Vaccination	Last Administration Da	te (MM/YYYY)	Vaccination	Last	Administration Date (MM/YYYY)
Pneumonia			Hepatitis B		
Flu			DT		
Shingles			DPT		
Pneumococcal			Tetanus		
Tuberculosis (TB)			Other		
			Other		
PAST MEDICAL HISTOR	Y: PLEASE CHECK ALL THE BOX	FS ΤΗΔΤ ΔΡΡΙ Υ			
□ Anemia/Blood		Emphysema			Pancreatitis
☐ Arthritis		GERD			Sickle Cell disease
		Glaucoma			Sinusitis
Autoimmune of		Heart Disease			Stroke
		Hepatitis/Liver disease			Thyroid
		Hypercholesterol			Tuberculosis
		Hypertension			Ulcers
Colitis		Irregular heartbe	at		Other:
Diabetes		Kidney disease			
Any unusual childh	nood infections or illnesse	s?			



PATIENT HEALTH HISTORY

NAME: _____

MEDICAL SURGICAL HISTORY

Operation	Date (MM/YYYY)	Reason	Surgeon/Facility

HOSPITALIZATION

Have you been hospitalized with in the last year? \Box Yes \Box No

If yes, please describe reason, facility and dates:

SCREENING TESTS

Have you had any screening tests?

Screening Test	Completed	Date	Results
Mammogram	□ Yes □ No □ N/A		
Breast Exam	🗆 Yes 🗆 No 🗆 N/A		
Pap Smear/Pelvic Exam	🗆 Yes 🗆 No 🗆 N/A		
Stool for Occult Blood	□ Yes □ No □ N/A		
Colonoscopy/Sigmoidoscopy	□ Yes □ No □ N/A		
Prostate Exam	🗆 Yes 🗆 No 🗆 N/A		
PSA	🗆 Yes 🗆 No 🗆 N/A		
Chest X-Ray/CT (Smokers)	🗆 Yes 🗆 No 🗆 N/A		
Bone Density	🗆 Yes 🗆 No 🗆 N/A		
Dermatology Skin Screening	🗆 Yes 🗆 No 🗆 N/A		
Eye Exam	□ Yes □ No □ N/A		
Other:			



PATIENT HEALTH HISTORY

Name: _____

SOCIAL HISTORY						
Number of Children:						
ALCOHOL USE						
Do you drink beer, wine, or liquor? \Box \	/es 🗆 No					
If yes, How many drinks per:						
Day: Week:	Month: Year:					
Did you quit? 🗆 Yes 🛛 No						
When did you quit?						
Have you ever sought help for drinking	? 🗆 Yes 🗆 No					
SMOKING USE						
Do you currently smoke? \Box Yes \Box No)					
If yes, what do you smoke?						
□ Cigarettes	How often per Day/Week:					
Cigars	How often per Day/Week:					
🗆 Pipe	How often per Day/Week:					
Electronic Cigarettes	How often per Day/Week:	-				
Smokeless/Chewing Tobacco	How often per Day/Week:	-				
Did you ever smoke? 🛛 Yes 🗌 No						
If yes, how long did you smoke for?						
When did you quit?						
Do you wear a nicotine patch?						
DRUG USE (RECREATIONAL)						
Do you use recreational drugs, includin						
If yes, what do you use:						
How often:						
If marijuana, is it medical marijuana? 🗆 Yes 🗀 No						
Have you previously used recreational	-					
If yes, when did you quit:						



NAME:

PREFERRED PHARMACY

Please indicate the pharmacy you are currently using for your prescriptions. If you are using a mail order pharmacy, specialty pharmacy or another pharmacy out of state, please include that information as well.

Pharmacy Name:			Type (circle one):	Retail	Mail Order	Specialty
Address/Cross Roads						
City:	State:	Zip Code:				
Phone number:		Fax number:	:			
Pharmacy Name:			Type (circle one):	Retail	Mail Order	Specialty
Address/Cross Roads	:					
City:	_ State:	Zip Code:				
Phone number:		Fax number:	:			

MEDICATION LIST

Please list all the medications you are currently taking. Be sure to include the dosage, how often and the doctor that has prescribed this medication for you. If you are taking any vitamins, over the counter medications or herbal supplements please also include these medications in the list below (you do not need to include the prescribing physician if not applicable).

PRESCRIPTION / OVER-THE-COUNTER						
Drug Name	Dose/Strength of Medication	How often you take Medication	Prescribing Physician			

Please list any herbal supplements you are currently taking (probiotics, vitamins, etc.).

Herbal Supplements	Dose/Strength	How often you take Supplement



NAME: ____

ALLERGIES

Do you have any allergies? \Box Yes \Box No

If yes, please list any medications, food or substances that you are allergic to. If applicable, please list the reaction (i.e. swelling, itching, shortness of breath, etc.)

Name of medication, food or substance:	Type of Reaction:
	1



NAME: _____

Hypertension

Stroke

FAMILY MEDICAL HISTORY

Please mark (Y) for all those that apply to YOUR FAMILY. Please mention relationship(s) to you and the age of diagnosis for each cancer in your family.

The following close blood relatives should be considered: You, parents, brothers, sisters, sons, daughters, grandparents, grandchildren, aunts, uncles, nephews, nieces, half-siblings, first cousins, great grandparents & great grandchildren.

YOUR	YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)							
	CANCER	YOU AGE OF DIAGNO SIS	Parents / Siblings / Children	AGE of Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE of Diagnosis	RELATIVES ON your FATHER'S SIDE	AGE of Diagnosis
⊠ Y □ N	Example: Breast Cancer				Aun t Cousin	45 61	Grandmother	53
□ Y □ N	BREAST CANCER (Female or Male)							
□ Y □ N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
□ Y □ N	Uterine (Endometrial) Cancer							
□ Y □ N	COLON/RECTAL CANCER							
□ Y □ N	10 or more LIFETIME COLORECTAL POLYPS (Specify #)							
□ Y □ N	OTHER CANCER(S) (Specify cancer type)							
□ Y □ N Are you of Ashkenazi Jewish descent?								
□ Y □	□ Y □ N Are you concerned about your personal and/or family history of cancer?							
Υ	 □ Y □ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible) 							

For other close blood relatives such as grandparents, aunts and uncles: Please check all boxes that apply

□ Anemia/Blood Disorders

Diabetes

□ Blood Clots

Heart Disease

Blood Disorders

FRM-005 Version 1.0



PATIENT HEALTH HISTORY

NAME: _____

REVIEW OF SYSTEMS

General Chills Weight Gain Night Sweats Headaches Ringing in ears Toothache Blackouts Sinusits Double Vision Blackouts Sinusits Double Vision Blackouts Sinusits Double Vision Blackouts Sore Throat Cataracts Hearing Loss Hoarseness Glaucoma Earache Sore Tongue Earache Bleeding Gums Nosebleeds Heart Murmur Cough Shortness of Breath Heart Murmur Sputum Chest Pain Rheumatic Fever Chughing Up Blood Palipitations High Blood Pressure Wheezing Swelling of feet Bronchitis Breast Lumps Gas Blood in stools Vomiting Gas Blood in stools Blood in stools Abdominal pain Constipation Gonstipations Hemorrhoids Vurinary Blood in urine Difficulty starting to Getting up at night to urinate Urinary Blood in urine Difficulty starting to Getting up at night to urinate Urinary			Fever		Weight Loss		Fatigue
Headaches Ringing in ears Toothache Blackouts Sinusitis Double Vision Seizures Post Nasal Drip Blurred Vision Dizziness Sore Throat Cataracts Hearing Loss Hoarseness Glaucoma Earache Sore Tongue Bleeding Gums Nosebleeds Neck Lumps Goiter Pain or Stiffness Pain when swallowing Difficulty swallowing Pain vhen swallowing Chest Cough Shortness of Breath Heart Murmur Sputum Chest Pain Rheumatic Fever Quiphing Up Blood Palpitations High Blood Pressure Wheezing Swelling of feet Bronchitis Breast Lumps Pain Nipple Discharge Vausea Ulcer Hemorrhoids Blood in stools Abdomen Indigestion Bloating Black stools Black stools Indigestion Bloating Black stools Black stools Black stools Urinary Burning with urination Bladder/Kidney Sense of full bladder Frequent urination <	General			_	•		_
Blackouts Sinusitis Double Vision Biackouts Post Nasal Drip Blurred Vision Dizziness Sore Throat Cataracts Hearing Loss Hoarseness Glaucoma Earache Sore Tongue Bleeding Gums Nosebleeds Neck Lumps Goiter Pain or Stiffness Pain when swallowing Difficulty swallowing Heart Murmur Sputum Chest Pain Rheumatic Fever Sputum Chest Pain Rheumatic Fever Sputum Chest Pain High Blood Pressure Wheezing Swelltmas Blood in stools Breast Lumps Pain Nipple Discharge Nausea Ulcer Hemorrhoids Black stools Abdomen Indigestion Bloating Black stools Black stools Indigestion Bloating Gasting up at night to urinate urinate Urinary Burning with urination Bladder/Kidney Sense of full bladder Infections Cramping Sense of full bladder Infections Frequent urination Bladder/Kidney Sense of full b							-
Head Seizures Post Nasal Drip Blurred Vision Dizziness Sore Throat Cataracts Hearing Loss Hoarseness Glaucoma Earache Sore Tongue Image and the seness Glaucoma Bleeding Gums Nosebleeds Pain or Stiffness Pain or Stiffness Neck Lumps Goiter Pain or Stiffness Pain when swallowing Difficulty swallowing Heart Murmur Sputum Chest Pain Rheumatic Fever Coughing Up Blood Palpitations High Blood Pressure Wheezing Swelling of feet Hemorrhoids Bronchitis Asthma Hemorrhoids Nausea Ulcer Hemorrhoids Nausea Ulcer Hemorrhoids Nousea Diarine Blood in stools Indigestion Bloating Black stools Abdominal pain Constipation Bloader/Kidney Burning with urination Bladder/Kidney Sense of full bladder Infections Infections Infections Frequent urination Bladder/Kidney Sense of full bladder<				_			
Head Dizziness Sore Throat Cataracts Hearing Loss Hoarseness Glaucoma Earache Sore Tongue Glaucoma Bleeding Gums Nosebleeds Pain Neck Lumps Goiter Pain or Stiffness Pain when swallowing Difficulty swallowing Pain or Stiffness Chest Cough Shortness of Breath Heart Murmur Sputum Chest Pain Rheumatic Fever Coughing Up Blood Palpitations High Blood Pressure Wheezing Swelling of feet Bronchitis Asthma Breast Lumps Gas Blood in stools Indigestion Bloating Black stools Blood in stools Mausea Ulcer Hemorrhoids Vomiting Gas Blood in stools Black stools Abdominal pain Constipation Black stools Indigestion Hatal Hernia Diarrhea Sense of full bladder Infections Frequent urination Bladder/Kidney Sense of full bladder Infections Frequent urination Duration				_			
Image: Hearing Loss Hoarseness Glaucoma Image: Earache Sore Tongue Image: Bleeding Gums Nosebleeds Neck Pain when swallowing Oifficulty swallowing Image: Cough Shortness of Breath Heart Murmur Sputum Chest Pain Rheumatic Fever Cough Shortness of Breath Heart Murmur Sputum Chest Pain Rheumatic Fever Whezing Swelling of feet High Blood Pressure Breast Lumps Pain Nipple Discharge Image: Nausea Ulcer Hemorrhoids Heart Murmur Abdominal pain Constipation Bload in stools Bload in stools Image: Hernia Diarrhee Image: Hernia Sense of full bladder Urinary Blood in urine Bladder/Kidney Sense of full bladder Image: Frequent urination Cramping Discharge Sense of full bladder Image: Frequent urination Bladder/Kidney Sense of full bladder Sense of full bladder Image: Frequent urination Duration: Interval: Interval: Interval: Image: Frequent <td>Head</td> <td>_</td> <td></td> <td>_</td> <td>•</td> <td>_</td> <td></td>	Head	_		_	•	_	
Bleeding Gums Sore Tongue Bleeding Gums Nosebleeds Neck Lumps Goiter Pain or Stiffness Pain when swallowing Difficulty swallowing Heart Murmur Cough Shortness of Breath Heart Murmur Chest Sputum Chest Pain Rheumatic Fever Chest Coughing Up Blood Palpitations High Blood Pressure Wheezing Swelling of feet High Blood Pressure Breast Lumps Asthma Hemorrhoids Nausea Ulcer Hemorrhoids Blood in stools Abdomen Blood in urine Difficulty starting to urinate Blood in stools Lurnary Blood in urine Difficulty starting to urinate Sense of full bladder Infections Frequent urination Bladder/Kidney Sense of full bladder Infections Infections Frequent urination Duration: Interval: Interval: Interval: May and infections Duration: Interval: Interval: Interval:				_			
Bleeding Gums Nosebleeds Neck Lumps Goiter Pain or Stiffness Pain when swallowing Difficulty swallowing Heart Murmur Cough Shortness of Breath Heart Murmur Chest Sputum Chest Pain Rheumatic Fever Chest Coughing Up Blood Palpitations High Blood Pressure Wheezing Swelling of feet Bronchitis Asthma Breast Lumps Pain Nipple Discharge Abdomen Indigestion Bloating Bload in stools Abdominal pain Constipation Bloating Black stools Urinary Burning with urination Bladder/Kidney Sense of full bladder Infections Infections Infections Infections Ist Menstrual Period: Duration: Interval: Interval: Mumber of pregnancies: Number of live births: Interval: Interval:			-		Sore Tongue		
Neck Lumps Goiter Pain or Stiffness Pain when swallowing Difficulty swallowing Cough Shortness of Breath Heart Murmur Sputum Chest Pain Rheumatic Fever Coughing Up Blood Palpitations High Blood Pressure Wheezing Swelling of feet Bronchitis Asthma Breast Lumps Pain Nausea Ulcer Hemorrhoids Vomiting Gas Blood in stools Abdomen Indigestion Bloating Black stools Abdominal pain Constipation Gater/Kidney Sense of full bladder Urinary Burning with urination Bladder/Kidney Sense of full bladder Infections Cramping Discharge Natifiections Spotting Cramping Discharge Natifiections Infections Lumps Duration: Interval:			Bleeding Gums		•		
Neck Pain when swallowing Difficulty swallowing Cough Shortness of Breath Heart Murmur Sputum Chest Pain Rheumatic Fever Coughing Up Blood Palpitations High Blood Pressure Wheezing Swelling of feet Bronchitis Asthma Breast Lumps Pain Nausea Ulcer Hemorrhoids Vomiting Gas Blood in stools Abdomen Indigestion Bloating Black stools Hital Hernia Diarrhea urinate Getting up at night to urinate Urinary Blood in urine Difficulty starting to Getting up at night to urinate Frequent urination Bladder/Kidney Sense of full bladder Mumber of pregnancies: Duration: Interval:					Goiter		Pain or Stiffness
Surfame Chest Pain Rheumatic Fever Chest Coughing Up Blood Palpitations High Blood Pressure Wheezing Swelling of feet Bronchitis Asthma Breast Lumps Pain Nipple Discharge Abdomen Nausea Ulcer Hemorrhoids Indigestion Bload in stools Blood in stools Abdomen Indigestion Bloating Black stools Hiatal Hernia Diarrhea Urinate Getting up at night to urinate Urinary Burning with urination Bladder/Kidney Sense of full bladder Infections Infections Infections Interval: Gynecology Spotting Cramping Discharge Instrual Period: Duration: Interval: Interval:	Neck				Difficulty swallowing		
ChestCoughing Up BloodPalpitationsHigh Blood PressureWheezingSwelling of feetBronchitisAsthmaBreastLumpsPainNipple DischargeNauseaUlcerHemorrhoidsVomitingGasBlood in stoolsNauseaBloatingBlood in stoolsAbdomenIndigestionBloatingBlack stoolsHiatal HerniaDiarrheaUrinateUrinaryBlood in urineDifficulty starting to urinateGetting up at night to urinate urinateFrequent urinationBladder/Kidney InfectionsSense of full bladder InfectionsGynecologySpotting Vaginal infectionsCramping Duration:DischargeMumber of pregnancies:Number of live births:Interval:			Cough		Shortness of Breath		Heart Murmur
WheezingSwelling of feetBronchitisAsthmaBreastLumpsPainNipple DischargeNauseaUlcerHemorrhoidsVomitingGasBlood in stoolsIndigestionBloatingBlack stoolsAbdomenIndigestionDiarrheaHiatal HerniaDiarrheaUrinaryBlood in urineDifficulty starting to urinateGetting up at night to urinate urinateFrequent urinationBladder/Kidney InfectionsSense of full bladder InfectionsGynecologySpotting Urajnal infectionsCramping Duration:DischargeInterval:Duration:Interval:Number of pregnancies:Number of live births:Interval:			Sputum		Chest Pain		Rheumatic Fever
Bronchitis Asthma Breast Lumps Pain Nipple Discharge Nausea Ulcer Hemorrhoids Vomiting Gas Blood in stools Indigestion Bloating Black stools Abdomen Indigestion Diarrhea Hiatal Hernia Diarrhea Urinary Blood in urine Difficulty starting to urinate Burning with urination Bladder/Kidney Sense of full bladder Frequent urination Bladder/Kidney Discharge Vaginal infections Cramping Discharge Last Menstrual Period: Duration: Interval: Number of pregnancies: Number of live births: Interval:	Chest		Coughing Up Blood		Palpitations		High Blood Pressure
Breast Lumps Pain Nipple Discharge Abdomen Nausea Ulcer Hemorrhoids Abdomen Indigestion Gas Blood in stools Abdominal pain Constipation Black stools Hiatal Hernia Diarrhea Urinary Blood in urine Difficulty starting to urinate Getting up at night to urinate Burning with urination Bladder/Kidney Sense of full bladder Frequent urination Cramping Discharge Vaginal infections Duration: Interval: Number of pregnancies: Number of live births: Interval:			Wheezing		Swelling of feet		
Abdomen Nausea Ulcer Hemorrhoids Vomiting Gas Blood in stools Abdomen Indigestion Bloating Bloot in stools Abdominal pain Constipation Black stools Hiatal Hernia Diarrhea Urinary Blood in urine Difficulty starting to urinate Urinary Burning with urination Bladder/Kidney Sense of full bladder Infections Frequent urination Bladder/Kidney Infections Spotting Cramping Discharge Vaginal infections Duration: Interval: Last Menstrual Period: Duration: Interval: Number of pregnancies: Number of live births: Interval:			Bronchitis		Asthma		
Abdomen Vomiting Gas Blood in stools Abdominal pain Bloating Black stools Hiatal Hernia Diarrhea Blood in urine Difficulty starting to urinate Getting up at night to urinate Burning with urination Bladder/Kidney Infections Sense of full bladder Frequent urination Cramping Discharge Vaginal infections Cramping Discharge Vaginal infections Duration: Interval: Last Menstrual Period: Duration: Interval:	Breast		Lumps		Pain		Nipple Discharge
Abdomen Indigestion Bloating Black stools Abdominal pain Constipation Black stools Hiatal Hernia Diarrhea Diarrhea Urinary Blood in urine Difficulty starting to urinate Getting up at night to urinate Urinary Burning with urination Bladder/Kidney Sense of full bladder Frequent urination Cramping Discharge Vaginal infections Duration: Interval: Last Menstrual Period: Duration: Interval: Number of pregnancies: Number of live births: Interval:			Nausea		Ulcer		Hemorrhoids
 Abdominal pain Constipation Hiatal Hernia Diarrhea Blood in urine Blood in urine Difficulty starting to urinate Burning with urination Bladder/Kidney Infections Frequent urination Spotting Cramping Discharge Vaginal infections Last Menstrual Period: Number of pregnancies: Number of Ive Births: 			Vomiting		Gas		Blood in stools
Hiatal Hernia Diarrhea Urinary Blood in urine Burning with urination Bladder/Kidney Frequent urination Bladder/Kidney Frequent urination Cramping Vaginal infections Duration: Last Menstrual Period: Duration: Number of pregnancies: Number of live births:	Abdomen		Indigestion		Bloating		Black stools
Urinary Blood in urine Difficulty starting to urinate Getting up at night to urinate Urinary Burning with urination Bladder/Kidney Sense of full bladder Image: Spotting Frequent urination Cramping Discharge Vaginal infections Duration: Interval: Interval: Number of pregnancies: Number of live births: Number of live births:			Abdominal pain		Constipation		
Urinary Burning with urination Bladder/Kidney Sense of full bladder Frequent urination Infections Discharge Yaginal infections Duration: Interval: Last Menstrual Period: Duration: Interval: Number of pregnancies: Number of live births: Interval:			Hiatal Hernia		Diarrhea		
Urinary Burning with urination Bladder/Kidney Sense of full bladder Frequent urination Infections Discharge Spotting Cramping Discharge Vaginal infections Duration: Interval: Last Menstrual Period: Duration: Interval: Number of pregnancies: Number of live births: Interval:			Blood in urine		Difficulty starting to		Getting up at night to urinate
Gynecology Spotting Cramping Discharge Last Menstrual Period: Duration: Interval: Number of pregnancies: Number of live births: Interval:					urinate		
Gynecology Frequent urination Spotting Cramping Discharge Vaginal infections Vaginal infections Last Menstrual Period: Duration: Interval: Number of pregnancies: Number of live births: Interval:	Urinary		Burning with urination		Bladder/Kidney		Sense of full bladder
Gynecology Spotting Cramping Discharge Gynecology Vaginal infections Interval: Interval: Last Menstrual Period: Duration: Interval: Interval: Number of pregnancies: Number of live births: Interval: Interval:					Infections		
Gynecology Uaginal infections Last Menstrual Period: Duration: Number of pregnancies: Number of live births:							
Gynecology Last Menstrual Period: Duration: Interval: Number of pregnancies: Number of live births: Interval:					Cramping		Discharge
Number of pregnancies: Number of live births:	Curreceleru		-				
	Gynecology	Last	t Menstrual Period:		Duration:		Interval:
Skin Rash Itching Change in hair or nails		Nur	mber of pregnancies:		Number of live births:		
	Skin		Rash		Itching		Change in hair or nails
Joint Stiffness Swelling Night Cramps	Neuron		Joint Stiffness		Swelling		Night Cramps
Neuromuscular Image: Source statules Image: Source statules Image: Imag	Neuromuscular		Joint Pain		Back Pain		Varicose veins
Easy bruising or bleeding Anemia Past Infusion			Easy bruising or bleeding		Anemia		Past Infusion
Hematological	Hematological		-				Transfusion Reactions
Endocrine Thyroid Problems Hot or cold intolerance Excessive thirst or hunger	Endocrine		Thyroid Problems		Hot or cold intolerance		Excessive thirst or hunger
Anxiety			Anxiety		Depression		Memory Loss
Psychiatric Nervousness	Psychiatric		•				



NAME: _____

OTHER PROVIDERS

Please list all providers involved in you care within the last 3 years:

Provider Type	Physician (first and last name)	Phone Number
Primary Care Physician		
Surgeon		
Cardiologist		
Endocrinologist		
Neurologist		
Urologist		
Pulmonologist		
Dentist		
Oral surgeon		
Optometrist		
Orthopedic		
Gynecologist		
Podiatrist		
Dermatologist		
Rheumatologist		
Other:		

Patient Signature: ______

Date: _____