CHANDLER PRIMARY CARE

Patient Name: ______________________________DOB: ___/___/__ Today's Date: ___/___/___

MEDICAL HISTORY/ CHRONIC CONDITIONS:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Review of Systems:

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain >10 pounds
- ☐ Weight Loss >10 pounds

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Night Awakening due to trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/Stopping urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

CHANDLER PRIMARY CARE

Patient Name: ___________________________________ DOB: ____/____/___ Today's Date: ___/____/___

SURGICAL HISTORY:

#	PROCEDURE	WHEN/WHERE	SURGEON
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

List if any additional Procedures: ____

Specialists, if applicable:

#	Specialty	Name	Last time seen
1	Cardiology		
2	Dermatology		
3	Electrophysiology		
4	Ear Nose Throat(ENT)		
5	Ophthalmology(Eye)		
6	Gastroenterology		
7	Gynecologist/OBGYN		
8	Hematology/Oncology		
9	Infectious Disease		
10	Nephrology		
11	Neurology		
12	Orthopedics		
13	Pain Management		
14	Podiatry		
15	Pulmonology		
16	Rheumatology		
17	Surgery		
18	Urology		
19	Vision		
20	Hearing/Audiology		

Any other specialists/Surgeons: ____

CHANDLER PRIMARY CARE

Patient Name: ______________________________ DOB: __/___/___ Today's Date: __/___/__

Medications and Supplement List

#	MEDICATION NAME	DOSE	FREQUENCY	PURPOSE	Prescriber
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

#	NAME OF SUPPLEMENT	PURPOSE
1		
2		
3		
4		
5		

Allergies:

#	Name of the Drug	Reaction	Other Allergies	Reaction
1			Radiographic Dye	
2			Latex	
3			Nuts	
4			Seafood	
5			Other Food Items	
6			Dust	
7			Pollen	
8			Bees	
9			Any Other	

Are you able to take medications as directed ☐ **Yes** ☐ **No** if no, reason? ________________

CHANDLER PRIMARY CARE

Patient Name: ________________________________ DOB: ___/___/___ Today's Date: ___/___/___

Tobacco: ☐ Never ☐ Past ☐ Current ☐ Environmental Exposure/2nd Hand

☐ Chew ☐ Smoke ☐ Other_____ ☐ >than 100 cigarettes smoke

_____ # of years smoked ___ Packs per day if Quit: Year you quit ______

☐ E Cigarettes/ Vaping

Drug Use: ☐ Never ☐ Past ☐ Current ☐ Occasionally Drug(s)____________________

☐ Drug dependence, If in remission, how long _____

Medical Marijuana User: ☐ Any Present or Past use of IV Drug Use: ☐

Recreational Marijuana User: ☐

Alcohol: ☐ Never ☐ Past ☐ Current ☐ Occasionally ☐ Socially

# of drinks _______ day/week/month/year ☐ Alcohol dependence, If in remission, how long _________

Caffeine: ☐ Never ☐ Occasionally ☐ Daily # of cups/day ________

Exercise: ☐ No ☐ Yes **Frequency:** **Type:**

Diet: Specify, if you have any major Diet restrictions:

Are you on any supervised weight loss diets? ☐ Yes ☐ No

How many meals do you eat in average day? _______

Describe your diet: balanced /Diabetic/ high fat/ high sugar/high protein/high salt

Home Environment: ☐ Private Home Who do you live with? : Self Spouse Family Others

☐ Assisted Living

Occupation: ☐ Retired, if so what was your occupation _________________

Any Asbestosis Exposure : ☐ Yes ☐ No

☐ Employed , What is your line of work: _____________ ☐ Unemployed ☐ Disabled

Advance Directives in place:

Living Will? ☐ Yes ☐ No **Medical Power of Attorney?** ☐ Yes ☐ No

Personal Safety:

Do you fall frequently: ☐ Yes ☐ No Do you feel safe at home: ☐ Yes ☐ No

Do you wear seat belts while driving: ☐ Yes ☐ No

Are you sexually active: ☐ No ☐ Yes, if so do you use condoms for protection: ☐ Yes ☐ No

CHANDLER PRIMARY CARE

Patient Name: _______________________________DOB: ___/___/__ Today's Date: ___/___/___

IMMUNIZATIONS:

VACCINE	MONTH/YEAR RECEIVED	VACCINE	MONTH/YEAR RECEIVED
Influenza/Flu		Tetanus/T-daP	
Pneumonia 23		Hepatitis A/ B	
Prevnar 13		HPV/ Gardasil	
Shingles		MMR	

SCREENINGS:

Screening test	Date	Where did you get it done	Results	
Colonoscopy			☐ Normal	☐ Abnormal
Stool Cards			☐ Normal	☐ Abnormal
Bone Density			☐ Normal	☐ Abnormal
Eye Exam			☐ Normal	☐ Abnormal
Annual Physical				

SCREENINGS (MEN ONLY):

Screening test	Date	Results		Done by
PSA/Prostate exam		☐ Normal	☐ Abnormal	PCP/ Urology
Testicular Exam		☐ Normal	☐ Abnormal	PCP/Urology

SCREENINGS (WOMEN ONLY):

Screening test	Date	Results		Done by
Pap smear		☐ Normal	☐ Abnormal	PCP/ GYN
Mammogram		☐ Normal	☐ Abnormal	PCP/ GYN / ONC

Which Imaging Center have you gotten your last Mammogram: ___________________________

Preferred Lab, for blood work: ________________________________

Preferred Radiology, for X-rays/CT scans, etc.: _________________________________

Preferred Hospital, if need to be admitted: ____

PHARMACY: ***Local****:* Name______________________ Phone No: _________________

Cross Roads : __________________________________ Zip Code: __________

Mail Order Pharmacy, if Applicable____

CHANDLER PRIMARY CARE

Patient Name: ______________________________ DOB: __/___/___ Today's Date: __/__/__

Family History :

	Father	Mother	Siblings	Children	Grandparents
Deceased	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Colon CA	☐	☐	☐	☐	☐
Breast/Prostate CA	☐	☐	☐	☐	☐
Other					

Any Medical Supplies You Use

Diabetic Supplies	Respiratory Supplies	Ambulation Modalities	Surgical Supplies
Diabetic Test Strips ☐	Oxygen ☐	Cane ☐	Mastectomy ☐
Diabetic Shoes ☐	Nebulizer ☐	Walker ☐	Colostomy ☐
	CPAP ☐	Wheelchair ☐	
Hearing Aids ☐		Hospital Bed ☐	