



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

GENTOURINARY

- 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	Neurology		
11	Orthopedics		
12	Pain Management		
13	Podiatry		
14	Pulmonology		
14	Rheumatology		
15	Surgery		
15	Vision		
16	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: ___/___/___

<p>Tobacco: <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current <input type="checkbox"/> Environmental Exposure/2nd Hand</p> <p><input type="checkbox"/> Chew <input type="checkbox"/> Smoke <input type="checkbox"/> Other _____ <input type="checkbox"/> >than 100 cigarettes smoke</p> <p>_____ # of years smoked _____ Packs per day if Quit: Year you quit _____</p> <p><input type="checkbox"/> E Cigarettes/ Vaping</p>
<p>Drug Use: <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current <input type="checkbox"/> Occasionally Drug(s) _____</p> <p><input type="checkbox"/> Drug dependence, If in remission, how long _____</p> <p>Medical Marijuana User: <input type="checkbox"/> Any Present or Past use of IV Drug Use: <input type="checkbox"/></p> <p>Recreational Marijuana User: <input type="checkbox"/></p>
<p>Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current <input type="checkbox"/> Occasionally <input type="checkbox"/> Socially</p> <p># of drinks _____ day/week/month/year <input type="checkbox"/> Alcohol dependence, If in remission, how long _____</p>
<p>Caffeine: <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily # of cups/day _____</p>
<p>Exercise: <input type="checkbox"/> No <input type="checkbox"/> Yes Frequency: _____ Type: _____</p>
<p>Diet: Specify, if you have any major Diet restrictions:</p> <p>Are you on any supervised weight loss diets? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many meals do you eat in average day? _____</p> <p>Describe your diet: balanced /Diabetic/ high fat/ high sugar/high protein/high salt</p>
<p>Home Environment: <input type="checkbox"/> Private Home Who do you live with? : Self Spouse Family Others</p> <p><input type="checkbox"/> Assisted Living</p>
<p>Occupation: <input type="checkbox"/> Retired, if so what was your occupation _____</p> <p style="text-align: right;">Any Asbestosis Exposure : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Employed , What is your line of work: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled</p>
<p>Advanced Directive Care:</p> <p>Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No MPOA? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Personal Safety:</p> <p>Do you fall frequently: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you wear seat belts while driving: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you sexually active: <input type="checkbox"/> No <input type="checkbox"/> Yes, if so do you use condoms for protection: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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	
Pevnar 13		HPV/ Gardasil	
Shingles		MMR	

SCREENINGS:

Screening test	Date	Where did you get it done	Results
Colonoscopy			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Stool Cards			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Bone Density			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Eye Exam			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Annual Physical			

SCREENINGS (MEN ONLY):

Screening test	Date	Results	Done by
PSA/Prostate exam		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	PCP/ Urology
Testicular Exam		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	PCP/Urology

SCREENINGS (WOMEN ONLY):

Screening test	Date	Results	Done by
Pap smear		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	PCP/ GYN
Mammogram		<input type="checkbox"/> Normal <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon CA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast/Prostate CA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other					

Any Medical Supplies You Use			
Diabetic Supplies	Respiratory Supplies	Ambulation Modalities	Surgical Supplies
Diabetic Test Strips <input type="checkbox"/>	Oxygen <input type="checkbox"/>	Cane <input type="checkbox"/>	Mastectomy <input type="checkbox"/>
Diabetic Shoes <input type="checkbox"/>	Nebulizer <input type="checkbox"/>	Walker <input type="checkbox"/>	Colostomy <input type="checkbox"/>
	CPAP <input type="checkbox"/>	Wheelchair <input type="checkbox"/>	
Hearing Aids <input type="checkbox"/>		Hospital Bed <input type="checkbox"/>	