LAKE SERENE CLINIC

Date of service: ____/____/____

Routine Preventive Healthcare Check List

Name: _____ Age: _____ DOB: ____/____/____ Gender: M / F

Medical History:

I see patients in my practice who are being hurt or threatened by someone they love. Is this happening to you? Yes / No

Allergies to medication, x-ray dye, etc? If yes, list substance and type of reaction:

_____

_____

_____

Medications & Supplements you are currently taking. List name, dose & frequency:

_____

_____

_____

_____

Other medical problems or concerns:

_____

_____

Past medical History and Review of Symptoms

Circle if you have or have had any of the following issues:

High Blood Pressure	Bronchitis	Change in bowel habits	Arthritis
Diabetes	Pneumonia	Unexplained weight change	Skin diseases
Cancer	Hemorrhoids	Persistent cough	Blood disorder
Heart disease	Tuberculosis	Gallbladder disease	Venereal disease
Chest pain/angina	Hay fever	Colitis	Anxiety
Shortness of breath	Indigestion	Hepatitis or jaundice	Depression
Swollen ankles	Anemia	Abdominal discomfort	Thyroid disease
Palpitations	Nausea	Lightheadedness	Headaches
Vomiting	Seizures	Kidney disease/hemodialysis	Alcohol abuse
Frequent urination	Constipation	Difficulty urinating	Drug abuse
Rheumatic fever	Diarrhea	Kidney stones	Vision difficulty
Asthma	Ulcers	Blood in stool	Hearing difficulty
Gout	Low back pain	Unexplained fever	Bladder leakage

Have you ever:

Had a blood transfusion or any blood products?	Yes	No
Been rejected for trying to donate blood?	Yes	No
Been told your liver function tests are elevated?	Yes	No
Been stuck with a needle or exposed to blood?	Yes	No
Been diagnosed with Hepatitis A, B, C or non A/B?	Yes	No
Had a sexually transmitted disease?	Yes	No

Circle: Gonorrhea / Chlamydia / HIV / Syphilis / Herpes

Operations/Hospitalizations

Reason	Date/Place	Physician

Social History

Marital status:_____ Occupation:_____ How long?_____
Do you have tattoos or body piercings?_____ Multiple partners now or in past?_____
Are your partners male, female or both?_____ Are you practicing safe sex?_____
Do you smoke?_____ How much?_____ How long?_____ Do you have a living will?_____
Do you drink alcohol?_____ Amount?_____ Frequency:_____ Type:_____
Do you drink coffee, tea or energy drinks?_____ How much daily?_____
Have you in the past or currently use or used intranasal cocaine in the past, even once?_____

Prevention History

Last Tdap (tetanus) vaccine:_____ Pneumonia vaccine:_____ Shingles vaccine:_____
Hepatitis B Vaccines:_____ Flu shot:_____ Other vaccines:_____
Last Dental Exam:_____ Eye Exam:_____ Optometrist:_____
Last Physical:_____Sigmoidoscopy:_____ Colonoscopy:_____ Fasting labs:_____

OB/GYN History

Last period:_____ Duration:_____ Regular?_____ Age of first period:_____
Number of pregnancies:_____ Live births:_____ Miscarriages:_____
Prolonged/abnormal bleeding?:_____ Pelvic Pain?:_____ Abnormal Discharge?:_____
Last PAP smear?_____ Abnormal PAP smear?:_____ When?:_____Treatment?:_____
Last Mammogram:_____ Where:_____ Bone Density Scan:_____
If you are sexually active, do you use anything for prevention of pregnancy and sexually transmitted diseases?_____ If not would you like to discuss options?:_____

Male History:

Last prostate exam:_____ Do you have frequent sudden urges to urinate?_____
Do you wake up during the night to urinate?_____ Frequency?:_____
How many times do you urinate a day?_____ Do you experience leaking accidents:_____
It is common for men to occasionally experience erection problems. Is this something happening to you?:_____ How often?_____ Discuss options?:_____

Family History:

Illness			**Which Family Member (Mother or Father's side)**
Alzheimer's	Yes	No	_____
Parkinson's	Yes	No	_____
Cancer	Yes	No	Type:_____
Heart Disease	Yes	No	_____
Diabetes	Yes	No	Type:_____
Stroke	Yes	No	_____
Hypertension	Yes	No	_____
Alcoholism	Yes	No	_____
Bleeding Disorder	Yes	No	_____
Mental Illness	Yes	No	Type:_____

Medical Problem (to be completed by provider)

_____
_____
_____