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Date:_____

Name:_____Gender:___M___F Date of Birth:____/____/____Age:_____

Please list any other heath providers that you have seen in the past 12 months (including providers of alternative/complimentary care):

_____

My main reason for the visit today is:_____

_____

Are there any family members or caretakers with whom you would like Dr. Biemer to freely discuss your medical issues?_____

MEDICATIONS

Please list ALL medications that you are currently taking or have taken in the past four weeks (including over-the-counter medicines, prescription drugs, vitamins, natural remedies, birth control pills, weight control preparations, etc.) from ANY provider (OK to continue on back):

Medication	Strength (mg)	Pills per Day	Date Started

ALLERGIES: Please list all medications (prescription or over the counter) with which you have had allergic or adverse reaction (or didn't work as intended).

Medication Reaction/Side Effect

1._____ _____

2._____ _____

3._____ _____

List any other allergies (food, pets, pollen etc)

_____

List any current or past significant Medical Illnesses, Hospitalizations, Surgeries, or

Injuries below (continue on back if you need):

_____
_____
_____
_____

WOMEN ONLY:

Last Gyn exam/ PAP test?_____Abnormal exams in past?_____
Date

Date of last Mammogram:_____Abnormals in past?_____
Do you regularly perform self-breast exams:___yes___no Date:

Method of Birth Control(if applicable):_____

Childbirth history (if applicable):
 # Pregnancies:_____# /# Vaginal deliveries:_____/#C-Sections:_____

IMMUNIZATION HISTORY:

Please indicate below the approximate date of your last immunization for each category, or please note if you had that disease in the past.

Tetanus(DT):_____ Measles/Mumps/Rubella:_____/_____Chickenpox:_____
Influenza(flu shot):_____ Pneumovax(pneumonia shot):_____
Hepatitis B:_____/_____/_____ Hepatitis A:_____/_____ Zostavax (Shingles)_____

FAMILY HISTORY:

Do you have a family history of any of the following? Enter the family member who has each condition:
Asthma/Allergies: _____ Bleeding Disorder: _____Diabetes: _____
Obesity/Overweight: _____ Heart Attack before age 60:_____
Stroke: _____ Hypertension: _____
Kidney or Liver Disease: _____Osteoporosis:_____
Colon Cancer: _____ Breast Cancer: _____ Prostate Cancer:_____
Other Cancers: _____
Depression/Suicides: _____ Anxiety Disorders: _____ Dementia: _____
Arthritis: _____ Migraine: _____ Alcoholism: _____

SOCIAL HISTORY

Occupation: If employed, what type of work do you do? _____
Marital/Family: Are you single/married/divorced/widowed? :_____
Children (ages) _____
Have you ever smoked cigarettes? _____ Please describe history, quit attempts, approximate amount of tobacco use, etc:_____
How much alcohol do you use? (Average # drinks per week) _____
Problems with alcohol or drugs in the past or present? _____
Are you drinking the same, less, or more than a year ago? _____
What type/amount of exercise do you get? _____
Do you have a living will/advance directive, medical power of attorney?_____

Review Of Systems

GENERAL SYMPTOMS	YES	NO	RESPIRATORY	YES	NO
CHILLS			COUGH		
FEVER			BLOODY SPUTUM		
NIGHT SWEATS			HOARSENESS/CHANGE IN VOICE		
EXCESSIVE BLEEDING			PHLEGM		
LOSS OF APPETITE			SHORTNESS OF BREATH		
WEIGHT LOSS			WHEEZES		
WEIGHT GAIN					
UNEXPLAINED FATIGUE					
SKIN	YES	NO	GASTROINTESTINAL	YES	NO
CHANGES IN MOLES			DIFFICULTY SWALLOWING		
ITCHING			HEARTBURN, NAUSEA, VOMITING		
LUMPS			ABDOMINAL PAIN OR INDIGESTION		
RASHES			CRAMPING		
ENT	YES	NO	DIARRHEA		
BLURRY OR DOUBLE VISION			CONSTIPATION		
DECREASE IN HEARING			MUCUS OR BLOOD IN STOOL		
RINGING IN EARS			DARK/BLACK STOOL		
VERTIGO			CHANGE IN BOWEL HABITS		
NASAL/SINUS CONGESTION			HEMORRHOIDS		
FREQUENT BLOODY NOSES					
			GENITOURINARY	YES	NO
CARDIOVASCULAR	YES	NO	PAIN/DISCOMFORT WITH URINATION		
CHEST PAIN OR PRESSURE			EXCESSIVE URINATION		
FAINTING/LIGHTHEADED			URINATION AT NIGHT--# OF TIMES___		
POUNDING/SKIPPING HEART			FREQUENT INFECTION		
ANKLE AND FOOT SWELLING			PROBLEMS WITH INCONTINENCE		
			NEUROLOGICAL	YES	NO
MUSCULOSKELETAL	YES	NO	HEADACHES		
PAIN IN BACK			SEIZURES		
MUSCLE PAIN/ACHE			PSYCHOLOGICAL	YES	NO
MUSCLE WEAKNESS			ANXIETY		
PAIN IN ARMS/LEGS			DEPRESSION		
			DIFFICULTY SLEEPING		
			LOSS OF APPETITE		
			DECREASED SEX DRIVE		
MEN ONLY	YES	NO	WOMEN ONLY	YES	NO
DECREASED URINARY STREAM			ABNORMAL VAGINAL BLEEDING		
PROBLEM WITH ERECTION			ABNORMAL VAGINAL DISCHARGE		
			PAIN WITH INTERCOURSE		
			VAGINAL ITCHING		
			BREAST LUMPS		
			NIPPLE DISCHARGE		
			HOT FLASHES		