Pilot Healthcare PL
Family Medicine

Patient Information

A. Please complete the following:

Name of Patient: _____
Last First Middle

Preferred Name: _____

Address: _____
Number & Street City State Zip Code

North (or other) Address: _____
Number & Street City State Zip Code

Telephone: Cell ( ) _____ Home ( ) _____

Email Address: _____ Race/Ethnicity: _____

Preferred Method of communication: ☐ Email ☐ Home Phone ☐ Mobile Phone ☐ Mail ☐ Work Phone

Social Security Number: _____ Date of Birth: _____

Primary Language: _____ Sex/Gender:_____

Sexual Orientation: ☐ Straight or Heterosexual; ☐ Lesbian, Gay, or Homosexual; ☐ Bisexual; ☐ Don't Know;
☐ Other: _____

Have you signed an Advanced Care Directive? _____

Who can be contacted in case of an emergency?

Name: _____

Address: _____

Telephone: Home ( ) _____ Cell ( ) _____

Relationship to you: _____

Referred by: _____

Medical History

A. Allergies

Do you have any allergies? Yes ☐ No ☐ Not sure ☐ If no, please go to the next section.

Drug Allergy			
Substance	Severity: Very Mild/ Mild/Moderate/Severe	Reaction	Onset: Childhood/ Adulthood/Unknown
Food Allergy			
Substance	Severity: Very Mild/ Mild/Moderate/Severe	Reaction	Onset: Childhood/ Adulthood/Unknown

Environmental Allergy			
Substance	Severity: Very Mild/ Mild/Moderate/Severe	Reaction	Onset: Childhood/ Adulthood/Unknown

B. Are you taking any prescription medication? Yes ☐ No ☐ If no, please go to the next section.
Please have the medications available for your visit. If you need more space, please write on the back.

Name of Medication	Dosage	Frequency	Any Side Effects?

Medication Retrieval Consent- Please check one of the following:
☐ I consent to retrieval of all of my medication from the database.
☐ Do not retrieve my non-controlled prescription history.

C. Are you taking any OTC/non-prescription medication? Yes ☐ No ☐ If no, please go to the next section.

Name of Medication	Dosage	Frequency	Any Side Effects?

D. Are you taking any vitamins, homeopathic or herbal medicines or supplements?
If no, please go to the next section.

Name of Medication	Dosage	Frequency	Any Side Effects?

B. Chief Complaint

Please describe what you are seeking treatment for: _____

_____

When did symptoms start? _____

Intensity of symptoms: ☐ Excruciating ☐ Mild ☐ Moderate ☐ Severe ☐ Other: _____

What makes symptoms worse? _____

What relieves symptoms? _____

E. Review of Symptoms:

Check ONLY the ones you NOW have or have had RECENTLY.

General						
☐ None	☐ Fatigue	☐ Fainting	☐ Fever	☐ Night Sweats	☐ Weakness	☐ Chills
Skin						
☐ None	☐ Color Changes	☐ Nail Change	☐ Hair Changes	☐ Moles		
☐ Rashes	☐ Itching	☐ Sores	☐ Dryness			
Head						
☐ None	☐ Injuries	☐ Bumps	☐ Headaches			
Eyes						
☐ None	☐ Blurred Vision	☐ Glaucoma	☐ Redness	☐ Itching		
☐ Burning	☐ Swelling	☐ Pain	☐ Dryness	☐ Tearing		
Ears						
☐ None	☐ Hard of Hearing	☐ Deafness	☐ Ringing	☐ Discharge		
☐ Room Spins	☐ Earache	☐ Itching	☐ Loss of Balance	☐ Dizziness		
Nose						
☐ None	☐ Decreased Smell	☐ Bleeding	☐ Pain	☐ Discharge		
☐ Obstruction	☐ Post Nasal Drip	☐ Deviated Septum	☐ Runny Nose	☐ Sinus Congestion		
Mouth						
☐ None	☐ Ulcers	☐ Sores	☐ Blisters	☐ Pain	☐ Bad Breath	
☐ Loss of Taste	☐ Dryness	☐ Bleeding Gums	☐ Dental Problems	☐ Bad Taste		
Throat						
☐ None	☐ Sore Throat	☐ Bad Tonsils	☐ Hoarseness			
☐ Pain	☐ Hard to Swallow	☐ Recurrent Infections	☐ White Spots			
Neck						
☐ None	☐ Stiffness	☐ Soreness	☐ Enlargement			
☐ Pain	☐ Lumps	☐ Masses				
Breasts						
☐ None	☐ Nodules	☐ Pain/Tenderness	☐ Changes	☐ Skin		
☐ Bloatedness	☐ Masses	☐ Bleeding	☐ Discharge			
Lungs						
☐ None	☐ Cough	☐ Phlegm	☐ Coughed Blood	☐ Wheezing		
☐ Shortness of Breath	☐ Pain in Lungs	☐ Chest Congestions	☐ Inhalant Exposure			
Heart						
☐ None	☐ Palpitations	☐ Chest Pains	☐ Varicose Veins	☐ Blood Clots	☐ Murmur	
☐ Swollen Extremities	☐ Cold Extremities	☐ Tightness/Pressure	☐ Rapid Heartbeat	☐ Blue Extremities		
Blood						
☐ None	☐ Broken Blood Vessels	☐ Anemia	☐ Easy Bruising			
☐ Prolonged Bleeding	☐ Swollen Nodes	☐ Painful Nodes	☐ Red Dots/Spots			
Gastrointestinal						
☐ None	☐ Abdominal Pain	☐ Nausea	☐ Vomiting	☐ Bloatedness		
☐ Belching	☐ Heartburn	☐ Indigestion	☐ Irregular Bowels	☐ Constipation		
☐ Diarrhea	☐ Gas	☐ Hemorrhoids	☐ Hernias	☐ Poor Appetite		
☐ Food Intolerance	☐ Bloody Stools	☐ Black Tarry Stools	☐ Excessive Appetite	☐ Rectal Bleeding		
Genitourinary						
☐ None	☐ Urgency	☐ Incontinence	☐ Straining	☐ Flank Pain	☐ Frequency	
☐ Stones	☐ Burning	☐ Bed Wetting	☐ Bloody	☐ Small Stream	☐ Dribbling	

☐ Urethral Discharge	☐ Cloudy Urine	☐ Unusual Color	☐ Urination at Night	☐ Hesitancy
Musculoskeletal				
☐ None	☐ Pain	☐ Weakness	☐ Cramps	☐ Twitching
☐ Injuries	☐ Back Pain			
☐ Join Stiffness	☐ Joint Pain	☐ Joint Swelling	☐ Joint Deformities	☐ Curvature of Spine
☐ Hot Joint				
Neurological				
☐ None	☐ Seizures	☐ Loss of Sensation	☐ Vertigo	☐ Hand Trembling
☐ Paralysis	☐ Gait Shuffling			
☐ Incoordination	☐ Weak Grip	☐ Disorientation	☐ Slurred Speech	☐ Loss of Memory
☐ Lack of Concentration	☐ Slurred Speech	☐ Loss of Facial Expression	☐ Tingling/Numbing/Burning	
Psychiatric				
☐ None	☐ Suicidal Thoughts	☐ Worrying	☐ Obsessiveness	☐ Mania/Depression
☐ Anxiousness/Stress	☐ Indecisiveness	☐ Timid/Shy/Bashful	☐ Hallucinations	☐ Alcohol Abuse
☐ Multiple Personalities	☐ Sexual Difficulties	☐ Panic Attacks	☐ Compulsiveness	☐ Hyperventilation
☐ Drug Use	☐ Irritability	☐ Insecurity	☐ Insomnia	☐ Depression
☐ Numbness				
Endocrine				
☐ None	☐ Weight Loss	☐ Weight Gain	☐ Hoarseness	☐ Breast Changes
☐ Hypoglycemia	☐ Diabetes	☐ Heat Intolerance	☐ Cold Intolerance	
☐ Loss of Hair	☐ Extreme Thirst	☐ Voice Changes	☐ Excessive Hair	
Gynecological ☐ N/A				
☐ None	☐ Breakthrough Bleeding	☐ Menstrual Cramps	☐ Post-Menopausal	
☐ Vaginal Itching	☐ Labial Sores	☐ Labial Lumps/Nodules	☐ Irregular Menses	
☐ Hot Flashes	☐ Pain Between Menses	☐ Loss of Libido	☐ Mood Swings	
☐ Vaginal Discharge	☐ Painful Intercourse	☐ Night Sweats		
Menstrual Flow:	☐ Light	☐ Moderate	☐ Heavy	

Menstrual Flow

Date of Last Menses: _____
Date of Last PAP Smear: _____
Date of Last Mammogram: _____
Duration of Cycle (21-30 days): _____
Duration of Flow (3-7 days): _____
Age at 1st Period: _____
Age at Menopause: _____

Pregnancy

Number of Pregnancies: _____
Number of Still Births: _____
Number of Live Births: _____
Number of Miscarriages: _____
Number of Abortions: _____

Sexual Activity: ☐ Never ☐ Currently Active ☐ Active in the Past, but not within the last year

Number of Partners:

Last 6 months: _____ Last year: _____ Last 2 years: _____ Lifetime: _____

Contraception: ☐ No ☐ Yes

Type of Contraception: _____

F. Have you had any major medical illnesses, injuries or surgeries? Yes ☐ No ☐

Condition	Year	Where Treated?

G. Have you ever had a blood transfusion? Yes ☐ No ☐
If yes, please provide the year and reason for the blood transfusion: _____

_____ Year: _____

H. Are you receiving any other treatments (i.e., chemotherapy, physical therapy)? _____

I. Family Medical/Mental Health/Substance Abuse History

Place an X in the column that applies.

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis						
Asthma						
Dementia						
Depression						
Diabetes						
- Type I						
- Type II						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Obesity						
Osteoporosis						
Stroke						
Substance Abuse						
Breast Cancer						
Colon Cancer						
Skin Cancer						
Stomach Cancer						
Thyroid Cancer						
Ovarian Cancer						
Uterine Cancer						
Prostate Cancer						
Testicular Cancer						

J. Please list the dates for the following:

Annual Physical: _____ Results: _____

PSA: _____ Results: _____

Total Colectomy: _____ Results: _____

Colonoscopy: _____ Results: _____

Dexa Scan: _____ Results: _____

EKG: _____ Results: _____

Cardiac Testing: _____ Results: _____

TB Test: _____ Results: _____

K. Immunizations/Vaccinations

✓	Type	Date	✓	Type	Date	✓	Type	Date
☐	DPT:		☐	Mumps:		☐	Smallpox:	
☐	Typhoid:		☐	Tetanus:		☐	Measles:	
☐	Influenza:		☐	Polio:		☐	MMR:	
☐	Pneumoccocal:							

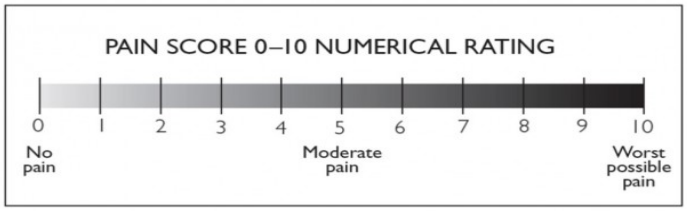
L. Have you ever tested positive for:

☐ Chicken Pox ☐ Hepatitis- Type: _____

☐ Tuberculosis ☐ Venereal (sexually transmitted) disease- Specify: _____

☐ HIV

M. Please circle your average pain level on the grid below.



Please describe the location of your pain: _____

N. Lifestyle

a. Have you ever smoked cigarettes? Yes ☐ No ☐

How many years have you smoked? _____

How many packs per day? _____

If you have quit, what year did you quit? _____

Have you used tobacco in other forms (pipe, cigars, chew)? Yes ☐ No ☐

Are you exposed to "second-hand smoke"? Yes ☐ No ☐

b. Do you drink alcoholic beverages? Yes ☐ No ☐

How many drinks per day/week/month? _____

c. Do you drink coffee or tea? Yes ☐ No ☐

d. Have you or your family recently experienced any changes or unusual psychological stress? Yes ☐ No ☐

If yes, explain: _____

O. Substance Use

In the last 12 months, have you used the following: Yes ☐ No ☐ If no, please go to the next section.

☐ Alcohol	☐ Ketamine	☐ Steroids (Anabolic)	☐ Ecstasy/MDMA
☐ Methamphetamine	☐ Synthetic Cannabinoids	☐ Prescription Opioids	☐ OTC Cough/Cold Meds
☐ Marijuana	☐ Psilocybin	☐ Prescription Sedatives	☐ Nicotine
☐ Cocaine	☐ Rohypnol	☐ Prescription Stimulants	☐ Other: _____
☐ Inhalants	☐ PCP	☐ GHB	☐ Other: _____
☐ Heroine	☐ LSD	☐ Salvia	☐ Other: _____

Age of first use: _____ Last substance(s) used: _____ Amount: _____ When: _____

P. Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Do you have any children? Yes ☐ No ☐ If yes, how many? _____

Q. Diet and Nutrition

Please characterize your current diet, describing your typical breakfast, lunch and dinner:

_____

Do you have an intolerance of any particular foods (lactose, gluten, etc.)?

_____

R. Exercise

Do you exercise regularly? Yes ☐ No ☐

What type of exercise and how often?

_____

S. Education

Highest degree or grade completed: _____

T. Employment

Are you employed? Yes ☐ No ☐ Retired? Yes ☐ No ☐ Are you a veteran? Yes ☐ No ☐

Occupation: _____

Disabled? Yes ☐ No ☐ If yes, reason: _____

U. Pharmacy Information:

Pharmacy: _____

Address: _____

Phone: ( ) _____

_____	_____	_____
Printed Patient Name	Patient Signature	Date