Dr. Flaming's Patients

All Patients

1. What is the reason for today's appointment? (Circle one)
   a) Physical exam (Complete #4,5,6)
   b) Routine Follow-up of stable problems: (Complete # 2,4,5,6)
   c) New or (worsening old problem) (Complete # 3,4,5,6)

2. Follow-up / check-up: What ***stable OLD*** problems are we checking on today? If here for a **new problem go to #3.**

   A._____ B. _____

   C._____ D. _____

Complete all that apply:

If hypertensive (have high blood pressure): Do you check blood pressures outside our office? _____
If yes, what do they usually run? _____
Headaches? _____ Chest pain? _____

If you are a diabetic: Do you check blood sugars outside our office? _____
If yes, what do they usually run (while fasting)?_____
Unexplained weight change? _____ Low sugars? _____

If you are hypothyroid (low thyroid): Do you take your medication on an empty stomach? _____
Have you missed any pills? _____
Constipation? _____ Fatigue? _____
Unexplained weight change? _____ Low sugars? _____

If you take cholesterol meds: Are you having any new, unexplained muscle pain or weakness? _____

If you have depression/anxiety: Are you sleeping well?____ Do you frequently feel sad or nervous? ____

If you have lung disease or asthma: Are you wheezing more or more short of breath? _____

3. Please complete these questions for **new (or worsening old) problem *for which this appointment was scheduled.* What is the new problem?**_____
   1) Duration (days, weeks, months)? _____
   2) What helps alleviate or worsens this problem? _____
   3) How severe is the problem? *(1-10, ten being worst)*_____
   4) Where is the problem located on your body? _____
   5) What are you usually doing when this occurs? (exertion, rest, eating, sleeping,other)_____
   6) Describe the pain (burning, pressure, sharp,dull) _____
   7) When does the problem occur? _____
   8) Do you associate this problem with any other signs or symptoms?
      _____

New Patients or *changes* in established patients only: Complete 4 + 5

4. **Family History:** What diseases run in your family? Mother: _____
   Father: _____Brothers or Sisters_____

5. **Social:** Please list how much tobacco you usually use per day?_____per week?_____ How many servings of beer, wine, alcohol or liquor do you have in a week?_____ About how many servings of caffeine do have each day? _____ Usual time of last caffeine? _____Do you smoke marijuana, and or use street drugs?_____ Have you ever used IV Drugs?_____

Reviewed by: _____ Date: _____ Pg 1

#6	Please circle any of these symptoms that apply to you

Constitutional:
* Fever/Chills
Feeling poorly
* Feeling tired
Recent weight gain/loss
Night sweats

Eyes:
Eye pain
Red eyes/Discharge
* Vision changes
Dry eyes
Itchy eyes

ENT:
*Earache
*Sore throat
Nasal congestion/discharge
Nosebleeds
Hoarseness
Hearing loss

Cardiovascular:
*Chest pain
*Irregular heart beats
*Lower extremity edema
Leg cramps/Pain with exercise
Slow heart rate
Fast heart rate

Respiratory:
*Shortness of breath
Shortness of breath during exertion
*Cough
Wheezing
Shortness of breath with lying down/at night

Gastrointestinal:
*Nausea and/or Vomiting
*Abdominal pain
*Diarrhea
Heartburn
Constipation
Trouble swallowing
Dark or bloody stool

Genitourinary:
*Pain with urination
*Frequency/Urgency of urination
Night time urination
Hesitancy
Incontinence (loss of urine control)
Blood in urine
Genital lesion
Difficulty with menstrual periods (females)
Erectile dysfunction (males)

Musculoskeletal:
*Joint pain
*Muscle pain
Joint swelling
Joint stiffness
Limb pain/swelling
Muscle cramps/weakness

Integumentary:
*Skin rash
* Itching
Skin lesions
Change in a mole
Breast pain/lump
Wound/Unusual growth on the skin

Neurological:
*Headache
*Dizziness
Mental changes
Fainting
*Limb weakness
Difficulty walking
*Numbness
Tremor
Radiating pain

Psychiatric:
*Anxiety
*Depression
Suicidal or homicidal thoughts
Personality changes/Irritability
Sleep disturbances

Endocrine:
Excessive thirst/urination
Drooping of eyelid
Hot or cold intolerance
Hair loss
Generalized weakness

Blood/Lymph:
Easy bruising/bleeding
Swollen glands

Here for a physical? Please answer the following questions:
Do you see a dentist regularly?
Do you see an eye doctor once a year?
Are your vaccines up to date-
Tetanus? Flu? Pneumonia? Hepatitis?
Do you eat a healthy diet?
Do you feel the need to lose weight?
Do you exercise regularly?
Do you use Tobacco? Alcohol? Drugs?
Are you sexually active?
Is so, do you use contraception?
If so, any problems?
Do you use seat belts regularly and drive safely?
Do you have smoke detectors?
Do you have a carbon monoxide detector?

What other health concerns do you have today?

All **NEW** patients or **CHANGES** in established patients
Please Complete

Past History:

Have you been treated for any of the following conditions in the past?
If so please list approximate dates of treatment and treating physician.

Condition	Approximate Dates of Treatment	Treating Physician
Psychological		
Diabetes		
GI Disease		
Liver Disease		
Heart Disease		
Phlebitis		
Anemia		
Arthritis		
Blood Disease		
Thyroid Disease		
Weight		
Cholesterol		
Seizures		
High Blood Pressure		
Stroke		
Genital/Urinary Disease		
Serious Accident		

Surgical History:

Condition	Approximate Dates of Treatment	Treating Physician

Hospitalizations:

Condition	Approximate Dates of Treatment	Treating Physician / Hospital

Marital Status: _____ Married _____Divorced _____ Single

Number of children: _____ **Number of pregnancies:** (if female) _____

List all allergies (including medical allergies)

updated: 11/24/2010

New Patients - Please list all medications and how you take them. Include over the counter meds, herbal meds, vitamins and supplements.

Established Patients - List any ***NEW*** meds since last visit.

	Medicine	Strength	How It's Taken	Prescribed by
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				

updated: 11/24/2010