WOODS FAMILY MEDICINE

ABBEY L. WOODS, MD

INITIAL VISIT INFORMATION

Patient's Name: _____ Date of Birth: _____

ALLERGIES:		
Current Medication Name	Dose	Frequency

Preferred Pharmacy: _____

Medical History	

Surgical History	

Social History			
Tobacco Use:	Current Use (how much)	Former Use (quit date)	Never used ☐
Nicotine Use:	Chew/Snuff/Dip?	E-cigarette Use?	Other nicotine supp? ☐
Alcohol Use:	_____drinks/week	Beer/Wine/Liquor	Never used ☐
Drug Use:	Yes, type:		Never used ☐

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Sexual History				
Partner Preference:	Male ☐	Female ☐	Both ☐	
History: (circle)	**Never sexually active** ☐	**Not currently** ☐	**Currently sexually active** ☐	
Last STD testing date: Circle if any positive		Chlamydia ☐	Gonorrhea ☐	Syphilis ☐
	HIV ☐	Herpes ☐	Trichomonas ☐	Chronic yeast ☐

Gynecologic and Obstetrical History					
Last menstrual period:		# Pregnancies?		# Live births?	
Last PAP testing (date)		Any abnormal results?			

Preventative History	
Colonoscopy: Date: _____ Where: _____ Results:_____	Immunizations: (month/year) Tdap: _____ PCV 13: _____ PCV 23: _____ Shingles:_____
Lung Cancer Screening: Date: _____ Where: _____ Results:_____	
WOMEN	MEN
Mammogram: Date: _____ Where: _____ Results:_____	Prostate Cancer Screening: Date: _____ Results:_____
Bone density screening: Date: _____ Where: _____ Results:_____	

Previous Physicians (primary care or specialists): Name, Specialty, Phone number, Address	

Family History	

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TODAY'S VISIT INFORMATION:

Patient's Name: _____ Date of Birth: _____

Reason for today's visit: _____

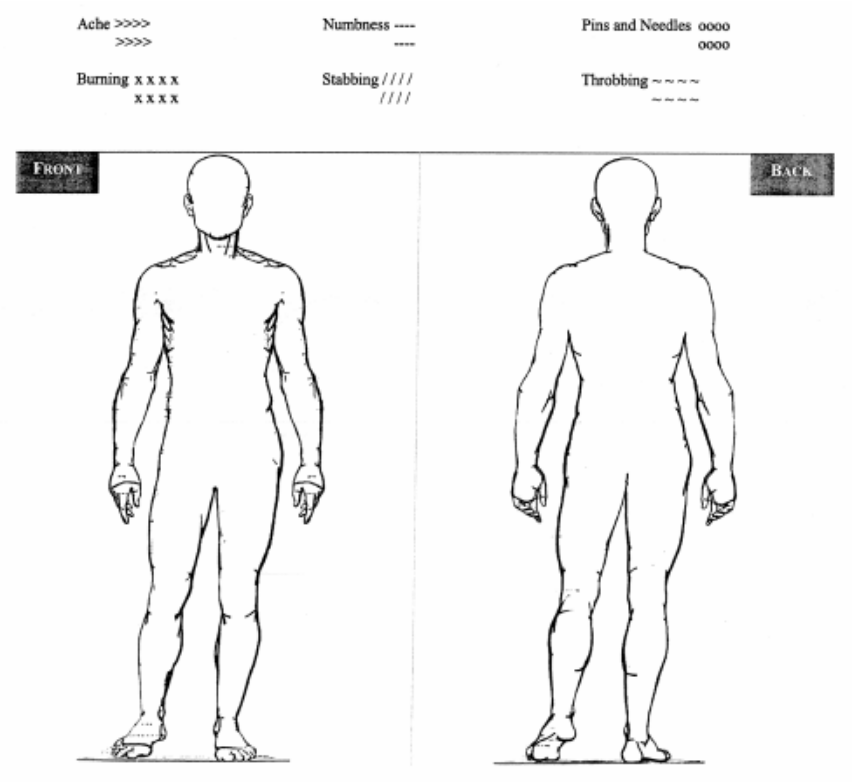
Any new medications since last visit? NO/ YES (explain) _____

Any specialist visit, ER, or hospitalization since last visit: NO/ YES (explain) _____

Any falls since last visit? NO/YES _____

Review of Systems:			
Over the last two weeks have you had any of the following: (circle)			
☐ Headache	☐ Blurry or double vision	☐ Nasal discharge/bleeding	☐ Trouble swallowing
☐ Lumps or bumps in neck	☐ Hoarseness	☐ Ear pain	☐ Ringing in ears
☐ Cough	☐ Chest pain	☐ Shortness of breath	☐ Palpitations (heart racing)
☐ Stomach pain	☐ Change in bowel habits	☐ Blood in urine or stool	☐ Numbness or tingling in hands or feet
☐ Fever	☐ Weakness	☐ Dizziness	☐ Leg swelling

Any pain today? NO/ YES
Where?



Do you need any medications refilled?
NO/ YES _____
_____
_____

Will you need a note for work or school?
NO/ YES _____