Paul R. Young, M.D. PLLC

Adult

GENERAL INFORMATION

Today's Date: _____ / _____ / _____ Social Security Number: _______-______-________

Name: ____ Date of Birth: _______ / _______ / _______

Last Name First Name MI

Address: ____

____

Phone Numbers: Home ( )_________________ Cell ( )___________________ Work ( )___________________

If we need to contact you, which is the preferred number? ☐ Home ☐ Cell ☐ Work

Can we leave a message at this number on the answering machine? ☐ Yes ☐ No Are there other members of the household that we may leave the message with regarding your health matters? ☐ Yes ☐ No If so whom?_____________________________

Patient's Email Address: ____

Occupation: ____ Employer: ____

Preferred Pharmacy (Name & Address): ____

____

Government regulations require we ask for the following identifying information.

Gender: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐Other____________

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Primary Preferred Language: ☐ English ☐ Spanish ☐ Other:______________________________________

REFERRING DOCTOR:

Did a doctor send you and do you want us to send the doctor a report about today's visit? ☐ Yes ☐ No

Doctor's Name: ____________________________ Primary care Doctor's Name:__________________________

ADULT REVIEW OF SYSTEMS: (If experiencing any of the below symptoms, please circle.)

General Constitutional:

☐ ☐ Change in Appetite
☐ ☐ Chills
☐ ☐ Fever
☐ ☐ Weight Loss

Ear, Nose and Throat:

☐ ☐ Decreased Hearing
☐ ☐ Ringing in Ears
☐ ☐ Dizziness
☐ ☐ Pressure in Ears
☐ ☐ Noise Exposure
☐ ☐ Sore Throat
☐ ☐ Swollen Glands
☐ ☐ Hoarseness / Voice Change
☐ ☐ Difficulty Swallowing
☐ ☐ Nose Bleeds

Endocrine:

☐ ☐ Temperature Intolerance
☐ ☐ Excessive Thirst
☐ ☐ Weight Loss

Respiratory

☐ ☐ Cough
☐ ☐ Shortness of Breath (At Rest)
☐ ☐ Shortness of Breath (Active)
☐ ☐ Wheezing

Cardiovascular:

☐ ☐ Chest Pain (At Rest)
☐ ☐ Chest Pain (Active)
☐ ☐ Irregular Heartbeat

Ophthalmologic (Eyes):

☐ ☐ Blurred Vision
☐ ☐ Eye Discharge
☐ ☐ Eye Pain

Gastrointestinal:

☐ ☐ Abdominal Pain
☐ ☐ Diarrhea
☐ ☐ Nausea
☐ ☐ Vomiting

Musculoskeletal:

☐ ☐ Painful Joints
☐ ☐ Weakness in Arms/Legs

Skin:

☐ ☐ Dry Skin
☐ ☐ Itching
☐ ☐ Rash

Neurologic:

☐ ☐ Headache
☐ ☐ Fainting
☐ ☐ Change in Taste / Smell

PAST MEDICAL HISTORY: (Please circle the symptoms below to indicate.)
Indicate if you have any of the medical problems listed below and add any additional problems not covered in the space provided.

- ☐ ☐ High Blood Pressure
- ☐ ☐ Coronary Artery Disease
- ☐ ☐ Angina (Chest Pain)
- ☐ ☐ High Cholesterol
- ☐ ☐ Asthma
- ☐ ☐ Emphysema / COPD
- ☐ ☐ Heartburn / GERD
- ☐ ☐ Kidney / Renal Disease
- ☐ ☐ History of Cancer
  Type:_______________________________________
- ☐ ☐ Arthritis
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid Problems
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Bleeding Disorder
- ☐ ☐ History of Clots in Lungs / Legs
- ☐ ☐ History of TMJ Dysfunction
- ☐ ☐ History of Migraine Headaches
- ☐ ☐ Immune Deficiency
- ☐ ☐ Stroke / CVA
- ☐ ☐ Autoimmune Disease
  (Rheumatoid, Lupus, Hashimotos, etc.)
- ☐ ☐ Other: __________________________________

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No ☐ Former Smoker, Quit Date: ______ / ______ / ______

If yes, how much? ____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much? ☐ 1-3 drinks/week ☐ 4-10 drinks/week ☐ 10+ drinks/week

Do you use recreational drugs (marijuana, cocaine, heroin, etc.)? ☐ Yes ☐ No

FAMILY HISTORY: (Please circle the symptoms below to indicate.)
Do any of these diseases run in your family:

- ☐ ☐ Diabetes (Please select: Maternal or Paternal side)
- ☐ ☐ Cancer (Please select: Maternal or Paternal side)
- ☐ ☐ Heart Disease (Please select: Maternal or Paternal side)
- ☐ ☐ Bleeding Disorders (Please select: Maternal or Paternal side)
- ☐ ☐ Anesthesia Complications (Please select: Maternal or Paternal side)
- ☐ ☐ Others: __________________________________

PAST SURGICAL HISTORY: Please list previous surgeries.

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____

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CURRENT MEDICATIONS: Please indicate doses and how often you take.

Medication	Dose	Frequency

ALLERGIES TO MEDICATIONS:

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