Family Medicine
OF ALBEMARLE

EXTENDED REVIEW

NAME: _____

Chart#:_____ Date:_____

***** Please help us update your medical record by completing this form. If you have already provided us with this information, please indicate any changes.***

Thank you!

Do you have any concerns that you wish to address today? _____
_____
_____

Please describe your symptoms: _____
_____
_____

this block for physician use only

Please state any serious past medical history, serious injuries, surgeries or hospitalizations: _____
_____
_____

Please list any medical conditions you are currently receiving treatment for: _____
_____
_____

What medicines are you currently taking? This includes prescription drugs, over-the-counter medicines, herbal supplements, vitamins, etc. _____
_____
_____

Medication Allergies: _____ Reaction:_____

Please tell us about your **Family History**.

Medical Condition	Yes	No	Relationship	Age
Breast Cancer				
Colon Cancer				
Prostate Cancer				
Diabetes				
High Blood Pressure				
Heart Disease or Heart attacks				
High Cholesterol				
Osteoporosis				
Thyroid Disease				
Other				

Social History:

Do you currently smoke (cigarettes, cigars, pipes)? Yes □ No □
Do you currently use smokeless tobacco (dip, snuff, chew)? Yes □ No □
Do you currently drink alcoholic beverages? Yes □ No □
number per week? _____
Have you ever had a legal, health or personal problem related to alcohol? Yes □ No □
Do you use any recreational drugs? Yes □ No □
Are you: Married Single Significant Other?
Do you have children? Yes □ No □ Ages / Sex _____
Are you employed? Yes □ No □ Occupation_____

(Over)

08/06

Health Risk/Prevention:

Do you do at least 30 minutes of aerobic exercise 3 or more times per week? Yes □ No □
If so, what type of exercise? _____
Do you have a physically active job or lifestyle? Yes □ No □
Have you felt depressed in the last month? Yes □ No □
Does your diet include the recommended number of fruits (2-3 servings) and vegetables (4-5 servings) per day? Yes □ No □
Do you take a daily vitamin? Yes □ No □
Do you wear your seatbelt? Yes □ No □
When was your last tetanus shot? _____ Flu shot? _____
Do you wear glasses or contacts? _____ Last eye exam: _____
Are you sexually active? Yes □ No □ If so, with men? □ women? □ both? □ spouse only? □
Risk factors for HIV (AIDS virus): More than one partner in the last 10 years
Homosexual partner
Previous IV drug use
Previous blood transfusion
Accidental needle exposure
Testing is recommended for anyone with any risk factor. Would you like to be tested? Yes □ No □

Results of your last cholesterol testing Total:____LDL:____HDL:____TG:____ Date:_____

Have you had your stool checked for blood? Yes □ No □
Had a flexible sigmoidoscopy or colonoscopy? Yes □ No □ Date:_____ Result:_____

Males:

Last Digital Rectal Exam/Prostate Exam: _____ Findings:_____
Do you perform Self Testicular Exam: _____ Questions/concerns: _____

Females:

Last PAP smear:_____ Ever have an abnormal PAP smear? _____
Last mammogram: _____ Ever have an abnormal mammogram? _____
Have you had your Bone Mineral Density (BMD) measured? _____ Result:_____
Contraceptive history:_____
Self Breast Exam: _____ Questions/concerns: _____
Last Menstrual Period: _____

Have you had any <u>recent</u> problems with the following (please check):

- ❑ Weight gain/loss
- ❑ Fever/chills
- ❑ Fatigue
- ❑ Heat/cold intolerance
- ❑ Increased hunger
- ❑ Increased thirst
- ❑ Not feeling yourself
- ❑ Blurry/Double vision
- ❑ Itching or watering of eyes
- ❑ Ringing of the ears
- ❑ Runny nose
- ❑ Nosebleeds
- ❑ Sinus pain
- ❑ Post nasal drip
- ❑ Sore-throat/ Hoarseness
- ❑ Allergies
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Difficulty breathing when lying down
- ❑ Fluid in your ankles
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough/coughing up phlegm
- ❑ Coughing up blood
- ❑ Nausea/vomiting
- ❑ Heartburn/reflux
- ❑ Abdominal pain
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in your stool
- ❑ Pain with urination
- ❑ Frequent urination
- ❑ Increased/urgent urination
- ❑ Blood in urine
- ❑ Urinary incontinence
- ❑ Changes in urinary stream
- ❑ Heavy or irregular periods
- ❑ Vaginal discharge, itching, burning or pain
- ❑ Sexual dysfunction
- ❑ Breast pain, nipple discharge, lumps
- ❑ Sores on penis
- ❑ Discharge from penis
- ❑ Hernia
- ❑ Impotence / erectile dysfunction
- ❑ Lumps/swelling in your scrotum
- ❑ Bruise easily
- ❑ Swollen glands
- ❑ Rash
- ❑ Sores that will not heal
- ❑ Unusual mole
- ❑ Problems with your hair or nails
- ❑ Skin becoming lighter or darker
- ❑ Headaches
- ❑ Loss of consciousness/ recent concussion
- ❑ Seizure
- ❑ Numbness
- ❑ Dizziness/vertigo
- ❑ Joint pain or stiffness
- ❑ Decreased strength
- ❑ Anxiety or panic attacks
- ❑ Depression
- ❑ Considered suicide
- ❑ Other _____