Cheryl L. Howard, D.O.

MEDICAL HISTORY

Name _____ **DOB** (MM/DD/YY) _____

Height _____ **Weight** _____ **Medication:** □ **No Change** _____

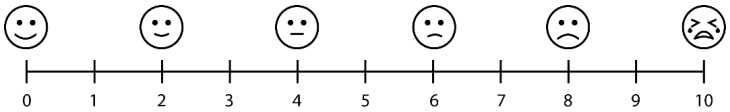
Reason for Visit _____ **Symptoms Start Date** _____

Description of Symptoms _____

_____

_____

Pain Scale (circle one)



Systems Affected

Musculoskeletal

Yes No
- □ □ Joint pain / swelling
- □ □ Head / Facial Pain
- □ □ Back Pain
- □ □ Neck Pain
- □ □ Hip Pain
- □ □ Upper Extremity Pain
- □ □ Lower Extremity Pain
- □ □ Muscle Pain
- □ □ Meds manage pain?
- □ □ Other _____

Neurological/Psychiatric

Yes No
- □ □ Dizziness
- □ □ Headaches / Migraines
- □ □ Memory Loss
- □ □ Difficulty Sleeping
- □ □ Excessive Sleeping
- □ □ Anxiety
- □ □ Depression
- □ □ Sad / Stressed
- □ □ Trouble Staying on Task
- □ □ Other _____

Respiratory/Cardiovascular

Yes No
- □ □ Cough
- □ □ Wheezing
- □ □ Short of Breath
- □ □ Pain with Breathing
- □ □ Chest Pain
- □ □ Numbness / Tingling
- □ □ Irregular Heartbeat
- □ □ Fainting Spells
- □ □ Other _____

General/ENT/Endocrine

Yes No
- □ □ Weight gain / loss
- □ □ Fatigue
- □ □ Fever/Chills
- □ □ Eye Pain
- □ □ Blurred/Double Vision
- □ □ Difficulty Hearing
- □ □ Ringing
- □ □ Nose Bleeds / Drainage
- □ □ Hair Loss
- □ □ Frequent Sore Throat

L/H/I / Skin

Yes No
- □ □ Swollen Glands
- □ □ Hives / Eczema
- □ □ Bleeding Gums
- □ □ Ulcers
- □ □ Difficulty Swallowing
- □ □ Rash / Sores / Lesions
- □ □ Itching / burning
- □ □ Clotting Issues
- □ □ Fatigue
- □ □ Other _____

Urology/Gastrointestinal

Yes No
- □ □ Frequency
- □ □ Pain/Burning
- □ □ Blood in Urine
- □ □ Diarrhea / Constipation
- □ □ Bloody / Black Stools
- □ □ Nausea/Vomiting
- □ □ Heartburn / Reflux
- □ □ Abdominal Pain
- □ □ Other_____

PATIENT SIGNATURE _____ **DATE** _____

Dr. Use Only_____

Vitals **BP** _____ / _____ **P** _____ **Ht** _____ **Wt** _____ **R** _____

Reviewed

HPI ☐ Medication List ☐ Labs / X-rays ☐ PF&SH ☐ Labs / X-rays ☐

Outside MR ☐ Peer to Peer ☐ Other _____

SIGNATURE/REVIEWING PHYSICIAN _____ **DATE** _____

Cheryl L. Howard, D.O.

CURRENT MEDICATIONS

INCLUDE BIRTH CONTROL PILLS,VITAMINS, AND SUPPLIMENTS

NAME	HOW TAKEN?	PRESCRIBING PHYSICIAN	NEED RX?	
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO

PREFERRED PHARMACY:_____LOCATION:_____

PHARMACY PHONE: _____ PHARMACY FAX: _____

PREVIOUS HEALTH CARE PROVIDERS & SURGERIES

NAME	CITY/STATE	PHONE/FAX	PROBLEM CARED FOR	STILL SEEING		REFERRAL?	
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO
				YES	NO	YES	NO

SURGERIES

TYPE	DATE

ALLERGIC/ADVERSE REACTIONS TO MEDICATIONS

NAME OF MEDICATION	ADVERSE REACTION

Additional Information

LAST MAMMOGRAM _____WHERE_____ LAST PAP _____ LAST GYN VISIT_____

LAST COLONOSCOPY_____NORMAL?_____DR_____REPEAT DATE_____

APPROXIMATE DATE OF LAST BLOODWORK_____RECTAL EXAM_____

VACCINE DATES:

TETANUS_____PNEUMONIA_____FLU_____HEPATITIS B SERIES_____

PATIENT SIGNATURE _____ **DATE** _____