www.alpinemedicalgroup.com

Name_________________________________**Date**________
Date of Birth______________**Place of Birth**_____________
E-mail Address_____________________________________
Preferred Method of Communication__________________
May we send general information about our clinic? YES/NO
Name of Primary Care Physician______________________

RETURN PATIENT HISTORY FORM

Have you been diagnosed with any new medical conditions or had surgery since you were last seen in this clinic?

□ NO □ YES

Explain: ____

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Have you been to the Emergency Room or admitted to the hospital since you were last seen in this clinic?

□ NO □ YES

Explain: ____

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Have you seen any other physicians or specialists since your last visit to this clinic?

□ NO □ YES

Explain: ____

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Has anyone in your family been diagnosed with any new medical condition since you were last seen in this clinic?

□ NO □ YES

Explain: ____

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Has there been any change to your personal or social situation since you were last seen here? (i.e. new job, change in living situation, smoking cessation or alcohol cessation)

□ NO □ YES

Explain: ____

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Do you have any new drug allergies since you were last seen here?

□ NO □ YES

Explain: ____

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REVIEW OF SYMPTOMS: Please place a mark next to any persistent symptoms you have had in the past few months. Read through every section and check “no problems” if none of the symptoms apply to you. List other concerns on back.

General:
__Fever/ chills
__Night sweats
__Unexplained weakness
__Excessive fatigue
__Decreased activity
__Unexplained weight loss/gain
__No Problems

Respiratory:
__Shortness of Breath
__Cough
__Wheezing
__Loud Snoring
__Short of breath – exercise
__Short of breath – lying down
__Coughing up Blood
__Coughing up Phlegm
__No Problems

Ear/Nose/Throat:
__Nose Bleeds
__Nasal Congestion
__Sore Throat/Hoarseness
__Trouble Swallowing
__Hearing loss
__Ear pain
__Dental cavities
__No Problems

Eye:
__Eye Mattering/Discharge
__Blindness
__Blurred/Double Vision
__Glasses/Contact Lenses
__No Problems

Neurological:
__Leaking Urine
__Headache
__Blood in Urine
__Memory loss/confusion

Skin:
__Rash
__Itching
__New Change in mole
__Hair Loss/Change
__Change in nails
__No Problems

Cardiovascular:
__Chest Pain/Discomfort
__Heart Palpitations
__Swelling in legs/feet
__No Problems

Gastrointestinal:
__Nausea/Vomiting
__Diarrhea
__Blood in Stools
__Hemorrhoids
__Constipation
__Abdominal Pain
__Heartburn/Reflux
__Indigestion
__Bloating
__Loss of bowel control
__Problems eating
__Loss of appetite
__Excessive gas
__Rectal Pain
__No Problems

Genitourinary:
__Leaking Urine
__Blood in Urine
__Nighttime Urination
__Urinating More Often
__Discharge: Penis or Vagina
__Concerns w/ Sexual Function
__Testicular Pain/lumps
__No Problems

Musculoskeletal:
__Back Pain
__Neck Pain
__Muscle Aches/Cramps
__Joint Pain
__Muscle Weakness
__Decreased Joint Motion
__Joint Stiffness
__No Problems

Hematologic/Lymphatic:
__Bruise Easily
__Bleeding Tendency
__Swollen glands
__No Problems

Endocrine:
__Heat Sensitivity
__Cold Sensitivity
__Excessive Hunger
__Excessive Thirst
__High/Low blood sugar
__No Problems

Neurological:
__Headache
__Memory loss/confusion
__Fainting
__Dizziness
__Numbness/Tingling
__Unsteady Gait
__Frequent Falls
__Tremors
__Seizures
__No Problems

Psychiatric:
__Anxiety/Stress/Irritability
__Sleep Problems
__Lack of Concentration
__Change in Behavior
__Change in Personality
__Anorexia
__Binging/Purging
__No Problems

Women Only:
__Pre-Menstrual Symptoms
__Excessive/Irregular Bleeding
__Hot Flashes/Night Sweats
__No Problems

Breasts:
__Breast Lump/Pain
__Nipple Pain
__Nipple discharge
__No Problems