PLATTSBURGH MEDICAL CARE

Today's Date:_____

At Plattsburgh Medical Care we strive to provide the highest quality comprehensive healthcare to our patients. In order to do this, we need to collect a variety of information which will help us create a plan of care. Please complete the following to the best of your ability.

Name:_____ DOB: ____/_____/_____
SSN:_____
Gender: Male □ Female □ **Marital Status**: □ Single □Partnered □ Married □ Divorced □ Widowed
Race: □ White □ Black/African American □ American Indian □ Asian □ Other:_____
Ethnicity: □ Hispanic □ Non-Hispanic
Preferred Language: □ English □ Spanish □ French □ Hindi □ Other:_____
Address:_____ Suite/Apt:_____
City:_____ State:_____ Zip:_____
Home Phone: (___)_____ Cell: (___)_____ Work: (___)_____
Preferred contact number: □ Home □ Cell □ Work

Occupation (or previous occupation):_____
Current Status: □ Part-Time □ Full-Time □ Retired □ LOA □ Unemployed □ Disabled
Years of Education or Highest Degree:_____ Employer:_____

Communication

Do you have hearing loss, wear hearing aids, or are deaf? □ Yes □ No
If yes, describe: _____
Do you have loss of vision, wear glasses or contacts, or are blind? □ Yes □ No
If yes, describe:_____
Have you been diagnosed with: □ Intellectual Disability □ Learning Disability

Allergies

□ No known food or drug allergies

Allergy	Reaction

Medications: □ I don't take any medications or supplements □ See attached list/I've brought my bottles

Medication	Dose	Frequency

Patient Name:_____ DOB:_____

Health Maintenance and Screening Tests:

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

Vaccination History

Last Tetanus Booster:	Last Pneumovax:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine (Shingles):	Hepatitis A/B Vaccination:

Personal Medical History

DISEASE/CONDITION	**CURRENT**	**PAST**	**COMMENT**
Alcoholism/Drug Abuse			
Asthma			
Cancer (type):_____			
Anxiety/Depression/Bipolar			
Diabetes (type):_____			
Emphysema/COPD			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Thyroid Disease			
Renal (kidney) Disease			
Migraines/Headaches			
Stroke			
Heart Disease			
Vascular (blood vessel) Disease			
Other:			
Other:			

Patient Name:_____ DOB:_____

Surgeries

TYPE	DATE	LOCATION/FACILITY

Women's Health

Date of Last Menstrual Cycle:	Age of First Menstruation:___ Age of Menopause:___
Total Number of Pregnancies:	Number of Births
Pregnancy Complications:	

Family Medical History: ☐ No Significant Family History ☐ Unknown

Condition	Age of Onset	Whom Affected	Deceased?
Alcohol Abuse/Drug Abuse			
Cancer (type):_____			
Emphysema/COPD/Asthma			
Depression/Anxiety			
Other Mental Health Condition:_____			
Diabetes			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Kidney Disease			
Stroke			
Thyroid Disease			
Other Endocrine Disease:_____			
Migraines/Headaches			
Seizures			
Other Neurologic Disorders:_____			
Other:_____			

Patient Name:_____DOB:_____

Social History and Health Habits

Do you have a caregiver? □ Y □ N If so, who?:_____

Tobacco Use:

Are you a smoker or use other tobacco products? □ Y □ N

Current Smokers: Packs/Day:_____ Age Started:_____

Previous Smokers: Average Packs/Day:_____ Age Started:_____ Age/Year Quit:_____

Other Tobacco Products Used: □ Pipe □ Cigar □ Snuff □ Chew □ Vape

Alcohol Use:

Do you Drink Alcohol? □ Y □ N Type: □ Beer □ Wine □ Liquor Number of Drinks/Week:_____

Other Substance Use:

Do you use marijuana/CBD products? □ Y □ N

Do you use other recreational drugs? □ Y □ N

Have you ever used injection drugs? □ Y □ N

Sexual Activity:

Are you sexually active? □ Y □ N Sexual partners are? □ Male □ Female

STD/Contraceptive Use: □ None □ Condoms □ Pill/Ring/Patch/Inj/IUD □ Vasectomy □ PrEP (Truvada)

Exercise:

Do you exercise regularly? □ Y □ N

What kind of exercise do you do?_____

How many minutes each session?_____ How often do you workout?_____

Sleep:

How many hours of sleep do you average per night?_____

Diet:

How would you rate your diet? □ Good □ Fair □ Poor

Do you follow a particular diet or have any dietary restrictions?

□ Low Carb □ Low Sodium □ Diabetic Diet/Exchange Diet □ Renal Diet □ Glutton Free □ Lactose Free

□ Other:_____ Would you like dietary advice? □ Y □ N

Safety:

Do you use a bike helmet? □ Y □ N Do you use seat belts consistently? □ Y □ N

Working smoke/carbon monoxide detectors? □ Y □ N Is violence at home a concern for you? □ Y □ N

If you have guns in the home are the locked up? □ Y □ N

Have you completed an Advanced Directive, Living Will or Healthcare Proxy? □ Y □ N

Specialists:

Name	Specialty	Last Visit

Patient Name: _____ DOB: _____

Are you currently suffering from any of the following symptoms?

General:
□ Chills
□ Fatigue
□ Fever
□ Night Sweats
□ Sleep Difficulties
□ Weight Gain
□ Weight Loss

Skin:
□ Bruising
□ Changing Mole(s)
□ Dryness
□ Hair Loss
□ Itching/Rash
□ New Lesions
□ Scalp Problems
□ Yellowing of the Skin

Eyes/Ears/Nose/Throat:
□ Earache
□ Gums Bleeding
□ Decrease in Hearing
□ Nose Bleeds
□ Ringing in the Ears
□ Runny Nose
□ Sinus Pain
□ Sore Throat
□ Throat Hoarseness
□ Visual Disturbances
□ Vomiting Blood

Neck:
□ Neck Pain
□ Neck Mass
□ Swollen Glands

Respiratory:
□ Cough
□ Coughing Up Blood
□ Shortness of Breath
□ Sputum Production
□ Wheezing
□ Low Exercise Tolerance
□ Waking Gasping or Choking

Breasts:
□ Breast Pain
□ Breast Lump
□ Nipple Discharge

Cardiovascular:
□ Chest Pain
□ Chest Pressure
□ Palpitations

Gastrointestinal:
□ Abdominal Pain
□ Black, Tarry Stools
□ Constipation
□ Diarrhea
□ Difficulty Swallowing
□ Nausea
□ Rectal Bleeding
□ Vomiting
□ Indigestion

Female Genitourinary:
□ Pelvic Pain
□ Urinary Complaints
□ Excessive Vaginal Bleeding
□ Vaginal Discharge

Male Genitourinary:
□ Blood in the Urine
□ Impotence
□ Penile Discharge
□ Urinary Difficulty

Musculoskeletal:
□ Joint Pain
□ Muscle Pain
□ Muscle Weakness
□ Joint Swelling

Neurological:
□ Dizziness
□ Fainting Spells
□ Headaches
□ Memory Loss
□ Numbness
□ Seizures
□ Tremor
□ Weakness

Endocrine:
□ Appetite Changes
□ Excessive Thirst
□ Hot Flashes

Hematology:
□ Anemia
□ Blood Clots in the Legs
□ Blood Clots in the Lungs

Psychiatric:
□ Anxiety
□ Depression
□ Mood Changes
□ Change in Sleep Patterns