Blue Ridge Well Being

Dr. Rachel Hallmark, MD PhD

Name: _____ DOB: _____

Patient History

Height: _____ Weight: _____

Past Medical History – please check all that may apply to you personally, at present or in the past

	Current	Past	Never
Rheumatoid arthritis			
Joint replacement			
Epilepsy			
Polio			
Stroke			
Head Injury			
High blood pressure			
Heart disease			
Heart attack			
Bowel/intestinal problems			
GERD (acid reflux)			
Stomach ulcer			
Bladder problems			

	Current	Past	Never
Thyroid disease			
Diabetes			
Depression			
Anxiety			
Substance abuse			
Asthma			
Emphysema (COPD)			
Kidney Disease			
Hepatitis			
Cancer			
HIV			
tuberculosis			
Bleeding problems			
Blood clots			

Please list any other medical problems not marked above:

_____

_____

_____

_____

Surgical History

Procedure	Date	Notes:

Name: _____ DOB: _____

Medication Allergies: ☐ NO drug allergies

Medication name	Reaction

***Current Medications: Please attach a list of all current medications, including name, dosage, and how often you take it.

Family History: *Mother/father, brothers/sisters, or children*

Condition	Who?
Cancer (specify type)	
Diabetes	
Heart attack	
Stroke	
Thyroid disease	
Nerve or muscle disease	
Rheumatoid arthritis	
Other (please specify)	

Social History:

Marital status: ☐ single ☐ domestic partner ☐ married ☐ divorced ☐ separated ☐ widowed

Do you live alone? No Yes

Employment: Occupation: _____ ☐ work in home ☐ student ☐ retired ☐ disabled

Do you currently smoke? ☐ No ☐ Yes If yes, # packs per day: _____ how many years: _____

If no, did you previously smoke? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes If yes, amount and frequency: _____

Review of Systems: Please mark the symptoms that you have had ***in the last month***

	YES	NO
Fever		
Weight gain		
Weight loss		
Overwhelming fatigue		
Change in vision		
Change in hearing		
Trouble swallowing		
Chest pain		
Shortness of breath		
High blood sugar		
Incontinence (leaking) of stool		
Blood in stool or dark stool		
Constipation		
Nausea/vomiting		

	YES	NO
Incontinence (leaking) of urine		
Blood in urine		
Difficulty urinating		
Joint pain		
Joint swelling		
Tingling		
Numbness		
Weakness		
Headaches		
Easy bleeding		
Rashes or skin lesions		
Uncontrolled depression/anxiety		
Difficulty sleeping		