
Phone:
Fax:

Visit - Telemedicine Hx -

Medical History

What questions, concerns, or problems would you like to discuss during your visit?

Medical and surgical history.

Allergies, including your reaction. (Ex. short of breath, hives)

[CurrentAllergies]

Social History

Select your tobacco status.

If you quit smoking, what was the date?

How many years have you smoked?

How often you do drink alcohol?

List any illegal substances you use.

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Mark the following symptoms that you currently suffer from

Constitutional

<input type="checkbox"/> Fevers	<input type="checkbox"/> Chills	<input type="checkbox"/> Sweats
<input type="checkbox"/> Weakness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Decreased Activity
<input type="checkbox"/> Malaise	<input type="checkbox"/> Unexplained Weight Gain	<input type="checkbox"/> Unexplained Weight Loss
<input type="checkbox"/> Low Sex Drive	<input type="checkbox"/> Difficulty Sleeping	

Eyes

<input type="checkbox"/> Blurriness	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Visual Disturbance
<input type="checkbox"/> Pain		

Ears/Nose/Throat/Neck

<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Ear Pain	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Nosebleeds	

Respiratory

<input type="checkbox"/> Shortness Of Breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Sputum Production
<input type="checkbox"/> Wheezing		

Cardiovascular

<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling in Feet
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Fainting
<input type="checkbox"/> Shortness Of Breath During Sleep		

Gastrointestinal

<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Abdominal Pain

Genitourinary/Nephrology

<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Change in Urine Stream
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Unusual Discharge Flank Pain Urinary Incontinence

Musculoskeletal

Back Pain Neck Pain Joint Pain
 Muscle Pain Muscle Cramp Muscle Spasm
 Gait Disturbances Joint Stiffness Joint Swelling
 Trauma

Integumentary

Rash Itching Lesions
 Bruising

Neurological

Abnormal Balance Confusion Numbness
 Tingling Dizziness Headaches
 Loss of Coordination Memory Loss Seizures
 Tinnitus Tremors Vertigo

Psychiatric

Feeling Anxious Depressed Mood Suicidal Thoughts
 Hallucinations Stress Problems Suicidal Planning
 Thoughts of Harming Others

List any other symptoms

How long have you had these symptoms?

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Does anything help to alleviate these symptoms?

What is your pain level?