
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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- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Unusual Discharge | <input type="checkbox"/> Flank Pain | <input type="checkbox"/> Urinary Incontinence |
|--|-------------------------------------|---|

Musculoskeletal

- | | | |
|--|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Muscle Cramp | <input type="checkbox"/> Muscle Spasm |
| <input type="checkbox"/> Gait Disturbances | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Joint Swelling |
| <input type="checkbox"/> Trauma | | |

Integumentary

- | | | |
|-----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Itching | <input type="checkbox"/> Lesions |
| <input type="checkbox"/> Bruising | | |

Neurological

- | | | |
|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Abnormal Balance | <input type="checkbox"/> Confusion | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Loss of Coordination | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Tremors | <input type="checkbox"/> Vertigo |

Psychiatric

- | | | |
|---|--|--|
| <input type="checkbox"/> Feeling Anxious | <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Stress Problems | <input type="checkbox"/> Suicidal Planning |
| <input type="checkbox"/> 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?