SAED J. SAHOURI, MD, FACP

Name	☐ M ☐ F	DOB	Today's Date

Gender Identity: _____

Race: _____ Ethnicity: Hispanic / Non-Hispanic (circle one)

PERSONAL MEDICAL HISTORY: Do you currently have or have had in the past (mark all that apply)

_____Heart disease	_____High Blood Pressure	_____High Cholesterol	_____Cancer
_____Diabetes	_____Kidney Disease	_____Thyroid Problem	_____Headaches
_____Depression	_____Seizures	_____Stroke	_____Asthma/Lung Disease
_____Chest Pain	_____Irregular Heartbeat	_____Shortness of Breath	_____Dizziness
_____Easy Bruising	_____Swollen Ankles	_____Tingling/Numbness	_____Memory Loss
_____Weight Loss	_____Change in Appetite	_____Difficulty Swallowing	_____Increased Thirst
_____Blood in Stool	_____Blood in Urine	_____Painful Urination	_____Hemorrhoids
_____Osteoporosis	_____Arthritis	_____Joint Pain	_____Sore Muscles
_____Back Pain	_____Skin Rash	_____Fever	_____Sinus Trouble
_____Chronic Cough	_____Sore Throat	_____Ear Infection	_____Voice Change
_____Vision Change	_____Hearing Impairment	_____Genital Herpes/Warts	_____Vaginal Infection
_____Hot Flashes	_____Night Sweats	_____Sexual Concerns	_____Mood Swings

MEDICATIONS: Prescription and non-prescription medicines, vitamins, herbs, homeopathic, etc.
Include medication, dose, frequency _____

_____

_____

_____

_____

_____

ALLERGIES or reactions to medications:_____

HOSPITALIZATIONS AND SURGERIES: Please list all prior operations with dates

_____

_____

_____

IMMUNIZATIONS: Please list date of your most recent immunizations
Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____
Meningitis _____Pneumonia _____ Varicella (Chicken Pox) vaccine or illness _____
Tdap (Tetanus, Diphtheria, Pertussis) _____ Td (Tetanus, Diphtheria) _____
Hepes Zoster (Shingles) _____ Other _____

HEALTH MAINTENANCE SCREENING TESTS: Please list date of most recent screenings
Physical Exam _____
Sigmoidoscopy _____ or Colonoscopy _____ Abnormal? ___Yes ___ No

Women: Mammogram _____ Abnormal? ___Yes ___No
Pap Smear _____ Abnormal? ___Yes ___No Bone Scan _____ Abnormal? ___Yes ___No
Men: PSA (prostate) _____ Abnormal? ___Yes ___No

Have you had tests or services performed at a health fair or pharmacy?

Have you received other health care services (pelvic exam, Pap test, retinal eye exam, diabetic foot exam)?

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt, or uncle) with any of the following conditions. If deceased due a condition, please put age at death:

High Blood Pressure _____ High Cholesterol _____
Stroke _____ Asthma/COPD _____ _____ Thyroid Disease _____
Diabetes _____ Epilepsy/Seizure _____ Osteoporosis _____
Coronary Artery Disease (CAD) _____ Kidney/Bladder Disease _____
Cancer (specify type) _____

SOCIAL HISTORY

Tobacco Use

Cigarettes ___Never Quit Date_____
___Current Smoker: packs/day____#of yrs____
Other Tobacco___Pipe ___Cigar ___Snuff/Chew
Are you interested in quitting? ___No ___Yes

Alcohol Use

Do you drink alcohol? ___No ___Yes
# of drinks per week _____
If yes:
Have you ever felt you should cut down on your drinking? ___No ___Yes
Have people ever annoyed you by nagging about your drinking? ___No ___Yes
Have you ever felt guilty about your drinking? ___No ___Yes
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ___No ___Yes

Drug Use

Do you use recreational drugs? ___No ___Yes
If yes, what kind? _____
Have you ever used needles to inject drugs? ___No ___Yes

Sexual Activity

Sexually active: ___No ___Yes ___Not currently
Sexual Orientation: _____
How many sexual partners have you had in the last 12 months? _____ In your lifetime? _____
Birth control method/none needed?_____
Have your ever had any Sexually Transmitted Diseases (STDs)? ___No ___Yes

Women's Health History

Pregnancies _____ # Deliveries _____
Abortions _____ # Miscarriages _____
Age at start of periods ___ end of periods ___

OTHER CONCERNS

Exercise: Do you exercise regulary? ___Yes ___No
What kind of exercise? _____
How long? (minutes) _____ How often? _____

Fall Risk: Have you fallen in the past year? ___Yes ___No
If yes, how many times? ____
Are you afraid of falling? ___Yes ___No

Relationships PHQ2:

Are you often feeling down, depressed, or hopeless during the past month? ___Yes ___No
Do you often have little interest or pleasure in doing things in the past month? ___Yes ___No

Personal Needs:

Please indicate if you need assistance with any of the following:
___Dressing ___Feeding ___Toileting ___Grooming
___Bathing ___Shopping ___Laundry ___Ambulation
___Housekeeping ___Responsibility of medication
___Handling Finances

Have you completed a living will or durable power of attorney for healthcare? _____YES _____NO

Patient Signature _____ Reviewed by _____

Date _____