**Eagle Medicine Associates**

**Dr. Oleksandr Stupnytskyi**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Previous Medical Providers name and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact name (and relation to patient) and phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS (**PRESCRIPTION & OVER THE COUNTER MEDICINE) INCLUDE NAME, DOSAGE & FREQUENCY:

|  |  |
| --- | --- |
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

**MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS**

|  |  |  |
| --- | --- | --- |
| **PROBLEM/DATE** | **PROBLEM/DATE** | **PROBLEM/DATE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you had a transfusion of blood or blood products? □Yes □No If yes did you have any reaction? □Yes □ No

**PERSONAL & SOCIAL HISTORY**

**ALCOHOL/TOBACCO/DRUGS RISK SCREEN:**

Do you use cigarettes, pipes, cigars, or chew tobacco? □Yes □No

Do you drink alcohol? □Yes □No If yes answer questions below.

 Ever tried to cut back on the amount of alcohol you drink? □Yes □No

 Ever become angry when people discuss your alcohol? □Yes □No Ever felt guilty about anything you did because of your drinking? □Yes □No

 Ever had a drink before noon (eye opener)? □Yes □No

 Has your drinking affected your relationship with your family or friends? □Yes □No

 Has your drinking affected your work or school? □Yes □No

 Have you ever drunk alcohol while or before driving or driven while intoxicated? □Yes □No

Do you drink coffee, sodas or other caffeinated beverages? □Yes □No

Do you use any street drugs or abuse prescription pain medication? □Yes □No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Do you think you are at risk for HIV, AIDS or other sexually transmitted disease? □Yes □No

Have you ever been tested for HIV? □Yes □No

 If yes, when \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_. What was the result? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: □ Married □ Single □ Divorced □ Widow(er) □ Separated

Education: □ Jr. High School □ High School/GED □ Vocational School □ College □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have an Advance Directive? □Yes □No

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **FAMILY MEMBER** |  **AGE** |  **ALIVE/DECEASED** |  **HEALTH** |  **CAUSE OF DEATH** |
| Father |  | □Alive □ Deceased |  |  |
| Mother |  | □Alive □ Deceased |  |  |
| □ Brother □ Sister |  | □Alive □ Deceased |  |  |
| □ Brother □ Sister |  | □Alive □ Deceased |  |  |
| □ Brother □ Sister |  | □Alive □ Deceased |  |  |

|  |  |
| --- | --- |
| **FAMILY HISTORY RELATIVE** |  **RELATIVE** |
| 1.Alzheimer’s Disease □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 11.Iron Storage Disease □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2.Breast Cancer □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 12.High Blood Pressure □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3.Heart Disease □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 13.Ovarian Cancer □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4.Stroke □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | 14.Prostate Cancer □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5.Depression,Suicide □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 15.Skin Cancer □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 6.Diabetes □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 16.Thyroid Disease □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7.High Cholesterol □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 17.Sickle Cell Disease □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 8.Obesity □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 18.Anemia □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 9.Glaucoma □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 19.Macular Degeneration □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 10.Substance Abuse □Yes □No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 20.Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**HEALTH MAINTENANCE**

Last Stools, occult blood test:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Colonoscopy/Sigmoidoscopy:\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Dental Exam:\_\_\_\_\_\_/\_\_\_\_\_\_ Dilated Eye Exam:\_\_\_\_\_/\_\_\_\_\_ Foot Exam:\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WOMEN: Last: PAP smear:\_\_\_\_\_/\_\_\_\_\_ Mammogram:\_\_\_\_\_/\_\_\_\_\_ Breast Exam:\_\_\_\_\_/\_\_\_\_\_ Menstrual Period:\_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEN: Last: Rectal/Prostate exam:\_\_\_\_\_/\_\_\_\_\_ Testicular Exam:\_\_\_\_\_/\_\_\_\_\_ PSA:\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IMMUNIZATIONS: (last date/year received) Tetanus:\_\_\_\_\_\_\_\_\_\_\_ Hepatitis B vaccine:\_\_\_\_\_\_\_\_\_\_\_ MMR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flu:\_\_\_\_\_\_\_\_\_ Tuberculosis Skin Test(date & results):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Review the list of symptoms below.**

Check “Yes” box if you suffer from the symptoms or have any of the health issues listed in the past 6 months Check “No” box if you do not.

|  |  |  |
| --- | --- | --- |
| **CONSTITUTIONAL** | **SKIN** | **MUSCULAR SKELETAL** |
| Unexplained weight loss □Yes □No | Skin changes □Yes □No | Neck pain □Yes □No |
| Unexplained weight gain □Yes □No | Skin lesions □Yes □No | Gout □Yes □No |
| Fevers □Yes □No | Skin itching □Yes □No | Injury to limbs □Yes □No |
| Chills □Yes □No | Rashes □Yes □No | Joint pain □Yes □No |
| Fatigue □Yes □No | Dry skin □Yes □No | Joint stiffness □Yes □No |
| Nausea or Vomiting □Yes □No | **GASTROINTESTINAL** | Locking joints □Yes □No |
| **EYES** | Blood in stool □Yes □No | Back pain □Yes □No |
| Cataract □Yes □No | Change in movements □Yes □No | Red or Swollen in joints □Yes □No |
| Change in vision □Yes □No | Constipation □Yes □No | **HEMATOLOGY/ONCOLOGY** |
| Glasses □Yes □No | Diarrhea □Yes □No | Anemia or low blood □Yes □No |
| Red eyes □Yes □No | Difficulty Swallowing □Yes □No | Easily bruise □Yes □No |
| **ENMT** | Heart burn □Yes □No | Swollen lymph nodes □Yes □No |
| Bleeding from gums □Yes □No | Hemorrhoids □Yes □No | Cancers □Yes □No |
| Problems hearing □Yes □No | Black tarry stool □Yes □No | **PSYCHIATRIC** |
| Change in your voice □Yes □No | Nausea or Vomiting □Yes □No | Depression or sadness □Yes □No |
| Denture □Yes □No | Stomach Ulcers □Yes □No | Feel like hurting someone □Yes □No |
| Nose bleeds □Yes □No | **GENITOURINARY** | Feel like hurting yourself □Yes □No |
| Hoarse voice □Yes □No | Problems urinating □Yes □No | Problems with memory □Yes □No |
| Sinus problems □Yes □No | Blood in urine □Yes □No | Anxiety □Yes □No |
| Ringing in ears □Yes □No | Hernias □Yes □No | Problems concentrating □Yes □No |
| Mouth ulcers □Yes □No | Incontinence □Yes □No | Problems sleeping □Yes □No |
| **CARDIOVASCULAR** | Urination at night □Yes □No | **NEUROLOGY** |
| Angina □Yes □No | Sexual transmitted Dz. □Yes □No | Change in memory □Yes □No |
| Heart problems □Yes □No | Urinary urgency □Yes □No | Dizziness □Yes □No |
| Chest pain □Yes □No | **WOMEN ONLY** | Headaches □Yes □No |
| Leg pain with walking □Yes □No | Problems with your period □Yes □No | Imbalance □Yes □No |
| Problems with exercise □Yes □No | Vaginal dryness □Yes □No | Numbness □Yes □No |
| Swelling in legs □Yes □No | Problems with sex □Yes □No | Weakness □Yes □No |
| Problems lying flat □Yes □No | Vaginal discharge □Yes □No | Tremors □Yes □No |
| Skipping heart beats □Yes □No | Pain in breast □Yes □No | Seizures □Yes □No |
| Short of breath at night □Yes □No | Lumps in breast □Yes □No | **ENDOCRINE** |
| **RESPIRATORY** | Breast discharge □Yes □No | Problems with heat □Yes □No |
| Bronchitis □Yes □No | **MEN ONLY** | Problems with cold □Yes □No |
| Cough □Yes □No | Problems with erection □Yes □No | Swelling in neck □Yes □No |
| Coughing up blood □Yes □No | Dribbling of urine □Yes □No | Frequent urination □Yes □No |
| Shortness of breath □Yes □No | Weak urine stream □Yes □No | Excessive thirst □Yes □No |
| Wheezing □Yes □No | Pain in testicles □Yes □No | Changes in hair □Yes □No |