InfectiousCare
Specialists in the Management of Infectious Diseases

Date: _____

Name: _____ DOB: _____ Sex: _____
Last *First* *MI*

Occupation: _____ Place of Employment: _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed Number of Children: _____

Best Contact Number: _____

REASON FOR TODAY'S VISIT: _____

Have you ever been treated for this problem before? ___ YES _____ NO

If yes, please give details: _____

Do you consider this a work-related injury?: _____ YES _____ NO

If yes, date of injury: _____ Please describe your injury: _____

Have you see an infectious disease physician in the past for any reason? If so, please provide their name:

_____

Reason seen?_____

ALLERGIES
List all known allergies and reactions: _____

_____

_____

MEDICAL HISTORY *Check all that apply*:

	YES	Date		YES	Date		YES	Date
MRSA			Diabetes			Migraines		
VRE			Coronary Artery Disease			Seizures		
HIV			Heart Attack			Asthma		
Chlamydia			High Blood Pressure			Peptic Ulcer		
Gonorrhea			High Cholesterol			Anemia		
Genital Warts			Cancer			Rheumatoid Arthritis		
Herpes			Liver Disease			Cataract		
STD (other)			Thyroid Disease			Glaucoma		
Tuberculosis			Kidney Disease			Depression		
Pneumonia			Emphysema			Other Psychiatric		
Hepatitis			Heart Disease					
Rheumatic Fever			Stroke or TIA					

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SURGICAL HISTORY *Check all that apply*:

	YES	Date		YES	Date		YES	Date
Cholecystectomy			BKA			CABG		
Appendectomy			AKA			PTCA		
Tonsillectomy			Hip Replacement			Pacemaker		
Hysterectomy			Knee Replacement			AICD		
Mastectomy			Hernia Repair			Other		
Tracheostomy			BTL			Other		

Other Medical/Surgical History:_____

_____

RECENT HOSPITALIZATIONS: (List the most recent admissions first)

DATE	REASON for ADMISSION

FAMILY HISTORY: (*Please list any hereditary illnesses: (Examples: Immunodeficiency, Hypertension, Cancer, Diabetes))*

RELATIONSHIP	DIAGNOSIS 1	DIAGNOSIS 2	DIAGNOSIS 3

SOCIAL HISTORY *Check all that apply*:

Your Personal Habits: Do you?			**YES**	**NO**	**Date Quit**	**If Yes, how much/how often?**						
Smoke												
Drink Alcohol												
Use recreational/Intravenous street drugs						*Type:*						
Are you?												
Sexually active					**Gender**	*Male:*			*Female:*			
Protection/ Birth Control	*Condom*	*Diaphragm*	*Pill*	*IUD*	*Surgical*	*Spermicide*	*Implant*	*Rhythm*	*Injection*	*Sponge*	*Inserts*	*Abstinence*

ACTIVITIES/DAILY LIFESTYLE *Check all that apply*:

	YES	Comments		YES	Comments		YES	Comments
Blood Transfusions			Hobby Hazards			Military Service		
Occupational Exposure			Exposure to Animals/Pets			Travel		

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WOMEN ONLY:
Could you be pregnant? ____ YES ____ NO

HEALTH MANAGEMENT: *Please indicate when you last had each of the following exams and if the results were normal/abnormal:*

	Date	Normal	Abnormal		Date	Normal	Abnormal
Dental				Bone Density Test/DEXA			
Ophthalmology				Mammogram (female)			
Stress Test				Pelvic/Pap Smear (female)			
Colonoscopy (over age 50)				Rectal/PSA Exam (male)			

OTHER MEDICAL ISSUES:
Please list any other issues that you wish to discuss with the physician: _____

_____

_____

MEDICATIONS *List all current medications, prescription and nonprescription* (EXAMPLE : ASPRIN, HERBAL):

Medication	Dose	Frequency	Start Date

Name, address and/or phone number of your current pharmacy:_____

_____

If you are here for HIV care, please list all of your previous HIV medication regimens in the past and the duration:

_____

_____

_____

_____

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Have you received any of the following testing in the last year?

	YES	Date	Where
Urine Cultures			
Blood Cultures			
Other Cultures			
Biopsy Results			
X-Ray			
CT			
MRI			
Gallium Scan			
Sonogram			
Echocardiogram			

COMMUNICATION:

Who referred you to our practice?_____

If a physician referred you to our office please provide their name, address and phone number:

_____

Name, address and phone number of your primary care physician:

_____

Names, addresses and phone numbers of all physicians you wish receive a copy of your office visit notes:

_____
_____
_____
_____