Stephen M Popkin M.D.
4100 E. Mississippi Ave #600
Denver, CO 80246
Fax Number: 303-759-3515

Patients Name: **Date:**

Chief Complaint (Reason for visit)

History of Present Illness

List all presenting complaints (new and chronic) and describe in detail using the elements located in the margin. (Examples of complaints- depression, anxiety, insomnia, memory, medication side effects, substance abuse)

Elements
Please complete all elements the *first time* you fill out this form. For later visits check boxes if no change

Check if no changes since previous visit

- ☐ Location of Symptoms
- ☐ Duration: How long have you been experiencing the symptoms?
- ☐ Associated signs and symptoms
- ☐ Modifying Factors: What have you done to obtain relief from the symptoms?
- ☐ Severity: Mild, moderate, severe,or worst ever. 1-10 1: least 10: worst
- ☐ Timing: When do you experience the symptoms?
- ☐ Context: What situations or activities tend to bring on the symptoms?

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Past History

Check if no changes since previous visit

☐ Prior major illnesses and injuries:
(Include dates)

☐ Prior hospitalizations:
Medical and Psychiatric
(Include dates and condition treated)

Check if no changes since previous visit

☐ Prior surgeries:

☐ Allergies:
Medication, food, environmental

☐ Current Medications:
Include dosage, prescribing physician, condition for which medicine is prescribed, and duration of treatment. Include over the counter and herbal remedies. Also include response to medication and side effects.

Family History

Check if no changes since previous visit

☐ Health Status:
Of parents, siblings, children and ages.

☐ Major Illnesses:
List all major illnesses including psychiatric, neurologic, alcoholism, drug abuse, suicide, and suicide attempts, of family members. (include grandparents, uncles, and aunts)

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Social History

Check if no changes since previous visit

- ☐ Marital status and/or living arrangements
  If married how many times?
- ☐ Current Employment:
  How long employed?

Check if no changes since previous visit

- ☐ Level of Education:
- ☐ Use of Drugs, Alcohol, and Tobacco:
  How many drinks do you consume in the average day?
- ☐ What is the most you have had to drink in a 24 hr period during the last year?
- ☐ Check if you were or someone told you that you were drinking
  too much. If so, describe.
- ☐ Have you ever used drugs? If applicable include marijuana. Also include the last time you took drugs.

Sexual History

Check if no changes since previous visit

- ☐ Sexual preference
- ☐ Do you have any concern about your sexual experience?
- ☐ Do you have any history of sexual abuse or trauma?

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REVIEW OF SYSTEMS & ACTIVE MEDICAL PROBLEMS

	Current problems
1. Overall Health Status	yes___ none ___
2. Eyes	yes___ none ___
3. Ears/Nose/Mouth/Throat	yes___ none ___
4. Cardiovascular	yes___ none ___
5. Respiratory	yes___ none ___
6. Gastrointestinal	yes___ none ___
7. Genitourinary	yes___ none ___
8. Muscular	yes___ none ___
9. Skin	yes___ none ___
10. Neurological	yes___ none ___
11. Endocrine (glands)	yes___ none ___
12. Hematologic/Lymphatic (Blood diseases)	yes___ none ___
13. Allergies/Immune	yes___ none ___

NOTES IF CURRENT PROBLEMS