For preparation only. Do not email this form. ReassureMed will provide secure submission instructions.

1 Patient Information

Basic information about the patient

FULL NAME

DATE OF BIRTH (DD/MON/YYYY, E.G. 07/JUN/1985)

SEX

○ Male ○ Female ○ Other

TITLE

EMAIL ADDRESS

PREFERRED CONTACT METHOD

STREET ADDRESS

CITY

PROVINCE / STATE

POSTAL / ZIP CODE

HOME PHONE

CELL PHONE

WORK PHONE

2 Emergency Contacts & Physician

Who should we contact in an emergency, and who is your primary physician?

EMERGENCY CONTACT NAME

RELATIONSHIP

PHONE

SECOND EMERGENCY CONTACT NAME

RELATIONSHIP

PHONE

PRIMARY CARE PHYSICIAN (PCP)

PCP PHONE NUMBER

3 Current Concerns

Tell us what prompted this consultation

CURRENT ISSUES / REASON FOR CONSULTATION

PRIOR TREATMENTS AND/OR TESTS PERFORMED

PAIN AREAS / BODY LOCATION

PAIN RATING (0-10)

ADDITIONAL COMMENTS

4 Medications, Allergies, and Supplements

List current medications, allergies, vitamins, and supplements

MEDICATION AND DOSAGE	ALLERGY	VITAMIN / SUPPLEMENT
MEDICATION AND DOSAGE 2	ALLERGY 2	VITAMIN / SUPPLEMENT 2
MEDICATION AND DOSAGE 3	ALLERGY 3	VITAMIN / SUPPLEMENT 3
MEDICATION AND DOSAGE 4	ALLERGY 4	VITAMIN / SUPPLEMENT 4
MEDICATION AND DOSAGE 5	ALLERGY 5	VITAMIN / SUPPLEMENT 5

Prior Illness, Injury, Hospitalization, Surgery, or Trauma

CONDITION / EVENT 1	DATE / TIMEFRAME
CONDITION / EVENT 2	DATE / TIMEFRAME
CONDITION / EVENT 3	DATE / TIMEFRAME

CONDITION / EVENT 4

DATE / TIMEFRAME

5 Review of Systems

For each category, select Yes or No. Add comments where helpful.

General
Weight change, fatigue, sleep, fever, rash, trauma, lumps
○ Yes ○ No

COMMENTS (OPTIONAL)

Eyes
Visual changes, headache, eye pain, double vision, floaters
○ Yes ○ No

COMMENTS (OPTIONAL)

Ears, Nose, Mouth, Throat
Sinus pain, ear pain, sore throat, swallowing difficulty
○ Yes ○ No

COMMENTS (OPTIONAL)

Cardiovascular
Chest pain, leg swelling, palpitations, fainting
○ Yes ○ No

COMMENTS (OPTIONAL)

Respiratory
Cough, wheeze, sputum, shortness of breath
○ Yes ○ No

COMMENTS (OPTIONAL)

Gastrointestinal
Abdominal pain, nausea, bloating, constipation, diarrhea
○ Yes ○ No

COMMENTS (OPTIONAL)

Genitourinary
Urination concerns, incontinence, irregular menses
○ Yes ○ No

COMMENTS (OPTIONAL)

Skin / Breast
Rashes, dryness, discoloration, breast soreness
○ Yes ○ No

COMMENTS (OPTIONAL)

Neurological
Seizures, headache, numbness, weakness, speech or balance issues
○ Yes ○ No

COMMENTS (OPTIONAL)

Psychiatric
Depression, anxiety, concentration changes
○ Yes ○ No

COMMENTS (OPTIONAL)

Endocrine
Heat/cold intolerance, thirst, urination, sweating, dizziness
○ Yes ○ No

COMMENTS (OPTIONAL)

Hematologic
Anemia, prolonged or excessive bleeding after injury
○ Yes ○ No

COMMENTS (OPTIONAL)

6 Health History

For each condition, select Yes or No

Alcohol Abuse ○ Yes ○ No	Anemia ○ Yes ○ No	Anxiety ○ Yes ○ No
Arthritis ○ Yes ○ No	Asthma ○ Yes ○ No	Atherosclerosis ○ Yes ○ No
Autoimmune Disorder ○ Yes ○ No	Bleeding Disorder ○ Yes ○ No	Blood Clots ○ Yes ○ No
Cancer ○ Yes ○ No	COPD / Emphysema ○ Yes ○ No	Depression ○ Yes ○ No
Diabetes ○ Yes ○ No	Diverticulitis ○ Yes ○ No	Heart Attack ○ Yes ○ No
Herniated Disc ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	HIV ○ Yes ○ No
Inflammatory Bowel Disease ○ Yes ○ No	Irritable Bowel Syndrome ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No
IV Drug Abuse ○ Yes ○ No	Kidney Disease ○ Yes ○ No	Kidney Stones ○ Yes ○ No

Liver Disease ○ Yes ○ No

Memory Loss ○ Yes ○ No

Migraines ○ Yes ○ No

Multiple Sclerosis ○ Yes ○ No

Osteoporosis ○ Yes ○ No

Reflux / GERD ○ Yes ○ No

Seizure Disorder ○ Yes ○ No

Stroke ○ Yes ○ No

Stomach Problems ○ Yes ○ No

Thyroid Problems ○ Yes ○ No

Transient Ischemic Attack ○ Yes ○ No

Urinary Tract Infections ○ Yes ○ No

OTHER CONDITIONS / NOTES

7 Family History

Immediate family conditions, relationship, age at diagnosis, comments

Condition	Relationship	Age at Diagnosis	Comments
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Thyroid Disease			
Other (1)			
Other (2)			

8 Social History

Lifestyle, employment, smoking, alcohol, exercise, rest, pregnancy

MARITAL STATUS

○ Single ○ Married ○ Common-law ○ Divorced ○ Widowed ○ Other

EMPLOYMENT STATUS

○ Employed ○ Self-employed ○ Retired ○ Student ○ Unemployed ○ Other

OCCUPATION

Do you currently smoke cigarettes?

○ Yes ○ No

IF YES, YEARS SMOKED / PACKS PER DAY

Did you ever smoke?

○ Yes ○ No

IF YES, WHEN DID YOU QUIT?

Do you drink alcohol?

○ Yes ○ No

IF YES, DRINKS PER WEEK

Do you use recreational drugs?

○ Yes ○ No

IF YES, WHICH?

Do you manage stress well?

○ Yes ○ No ○ Not sure

Is your diet healthy enough?

○ Yes ○ No ○ Not sure

Do you exercise regularly?

○ Yes ○ No

IF NO, WHY NOT?

Do you allow time to relax?

○ Yes ○ No

IF NO, WHY NOT?

Do you sleep soundly?

○ Yes ○ No

IF NO, WHY NOT?

Do you enjoy your job?

○ Yes ○ No

IF NO, WHY NOT?

Are you currently pregnant?

○ Yes ○ No ○ Not sure

9 Consent and Privacy Acknowledgement

Please review and acknowledge the following statements

I consent to the use and disclosure of my Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations as described in the Notice of Privacy Practices.

I acknowledge that I have received and reviewed the Notice of Privacy Practices.

PATIENT NAME (PRINTED)

DATE

RELATIONSHIP TO PATIENT (IF SIGNING ON BEHALF)

SIGNATURE (TYPE FULL LEGAL NAME)

RESTRICTIONS / ADDITIONAL COMMENTS