Boonslick Medical Group
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St. Peters, MO 63376
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Dr. Robert Cusworth, M.D.
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Please complete your personal information and mark any condition with which you have had significant problems in the last 6 months

Today's Date:_____ Date of Appointment:_____
Name:_____ Date of Birth: _____ Age: _____
Reason for visit:_____
PCP:_____ Referring Physician: _____
Local Pharmacy:_____

	No	Yes
Constitutional		
Chills	___	___
Fatigue	___	___
Fever	___	___
Loss of appetite	___	___
Night sweats	___	___
Weight loss	___	___
Weight gain	___	___
HEENT		
Eye pain	___	___
Yellow eyes	___	___
Respiratory		
Chronic cough	___	___
Excessive snoring	___	___
Hoarseness	___	___
Known TB exposure	___	___
Shortness of breath	___	___
Wheezing	___	___
Cardiovascular		
Chest pain	___	___
Irregular heartbeat	___	___
Gastrointestinal		
Abdominal pain	___	___
Black stool	___	___
Bloating/Abd distention	___	___
Blood in stool	___	___
Change in bowel habits	___	___
Constipation	___	___
Diarrhea	___	___
Difficulty swallowing	___	___
Gas/ Flatulence	___	___
Heartburn/indigestion	___	___
Bowel accidents	___	___
Nausea	___	___
Reflux	___	___
Vomiting	___	___
Vomiting blood	___	___

	No	Yes
Genitourinary		
Pain with urination	___	___
Flank pain	___	___
Blood in urine	___	___
Kidney stones	___	___
Reproductive (female)		
Heavy menses	___	___
Metabolic/Endocrine		
Cold intolerance	___	___
Excessive thirst	___	___
Generalized weakness	___	___
Heat intolerance	___	___
Yellow skin	___	___
Neurological		
Dizziness/light headed	___	___
Headache	___	___
Focal weakness	___	___
Seizures	___	___
Psychiatric		
Anxiety	___	___
Depression	___	___
Sleep disturbance	___	___
Skin		
Severe itching	___	___
Rash	___	___
Musculoskeletal		
Back pain	___	___
Joint pain	___	___
Hematologic/Lymphatic		
Easy bleeding	___	___
Enlarged lymph nodes	___	___

Please fill this form out as completely as possible and bring this to your appointment

Past Medical History (please circle any medical problems that you have had in the past):

Anemia	Depression	Kidney stones
Anticoagulation therapy	Diabetes mellitus	Liver disease
Anxiety	Fatty liver	Myocardial Infarction (heart attack)
Arthritis	Fibromyalgia	Osteoporosis
Cancer	GERD (heartburn)	Pancreatitis
Cataracts	Heart disease or pacemaker	Primary biliary cirrhosis
Chronic lung disease	Hepatitis B	Primary sclerosing cholangitis
Cirrhosis	Hepatitis C	Rashes/ skin problems
Colon polyps	Hyperlipidemia (high cholesterol)	Renal Insufficiency
Congestive heart failure	Hypertension (high blood pressure)	Sleep apnea
Coronary artery disease	Inflammatory bowel disease	Thyroid disease
Crohn's disease	Irritable bowel syndrome	Ulcerative colitis
Deep vein thrombosis	Kidney disease	Other (specify)_____

_____

Past Surgical History (circle any surgeries you have had and the date of surgery if you know it):

Appendectomy	Cosmetic surgery	Hysterectomy
Bariatric surgery	C-Section	Kidney transplant
Bowel resection	Eye surgery	Liver transplant
Breast surgery	Heart surgery	Orthopedic surgery
Cholecystectomy (gall bladder removal)	Hepatobiliary surgery	Sterilization
Colonoscopy	Hernia repair	Vascular surgery

Other (specify)_____

Do you ever drink alcohol? Yes No How often?_____ Last drink?_____

If yes, please indicate the quantity per week of each:

Glass of wine_____ Cans/bottle of beer____ Shots of liquor_____

Drinks containing 0.5 oz of alcohol _____

Do you consume caffeine? Yes No

What type of caffeine and how often?_____

Circle one of the following about smoking tobacco:

Never smoked Former smoker Smoke some days

Smoke everyday Exposed to second hand smoke

If you smoke or used to smoke, how many packs do/did you smoke per day?_____

How many years did you smoke/have you smoked?_____

If you quit, when did you quit?_____

Do you use "smokeless tobacco"? (circle one below)

Former user Current user Never used

If you quit, when did you quit?_____

Are you ready to quit smoking and/or using smokeless tobacco? YES NO

Family History

Check below to report problems your family members have had. Please state the age when they had the problem if you know it.

I was adopted and I don't know my family history. _____

	Mother	Father	Sister	Brother	Son	Daughter	Other(Specify)
Alcohol Abuse							
Breast Cancer							
Cancer (Specify)							
Celiac Disease							
COPD							
Colon Polyps							
Colon Cancer							
Cystic Fibrosis							
Diabetes							
Heart Attack							
High Cholesterol							
Hypertension							
Inflammatory Bowel Disease							
Kidney Disease							
Liver Disease							
Other(Specify)							
Alive(Yes/No)							
If No, Age of Death.							

Please list any medications that you are currently taking. Please include any over-the-counter medications as well.

Medication name	Dosage	How often

Please list any allergies to medications.

_____

_____

_____

_____

_____