Office Of

Dr . Lydia Kapell

Confidential
Patient Medical
Records

Date: _____

Name: _____ DOB:_____ Last 4 SS#_____

Address: _____

City_____ State _____ Zip:_____

Phone: _____ Email: _____

Emergency Contact: _____Phone: (_____) _____-_____

Current Primary Care

Physician Name: _____ Office: _____

Address: _____

City_____ State_____ Phone: (_____)-_____-_____

Please check off the medical condition(s) in which you are here for today:

☐ Cancer - What kind? _____ How long? _____
☐ Glaucoma How long? _____
☐ HIV/AIDS How long? _____
☐ Hepatitis C How long? _____
☐ Cachexia (too thin for height) How long? _____
☐ Severe Pain: Location _____
How often? _____ Describe the pain: _____
Does the pain travel elsewhere? If so, where? _____
If you have pain, how bad does it get on a scale of 0-10? (10 being the worst) _____

☐ Severe Nausea How often? _____
☐ Migraine Headaches How often?_____
☐ Seizures How often? _____
☐ Multiple Sclerosis How long? _____
☐ PTSD How long? _____
☐ Depression How long?_____
☐ Anxiety Disorder How long? _____
☐ Insomnia How long? _____
☐ Other: _____
_____

Do you, or have you had any of the following? (Check all that apply)

☐ Diabetes	☐ Abdominal Problems	☐ Arthritis	☐ Heart Disease
☐ High Blood Pressure	☐ Muscle cramps	☐ Syncope	☐ Headaches
☐ Lung Disease	☐ Seizures	☐ Other:_____	

☐ Allergies to any medication? Name(s) _____

Is there a chance you are currently pregnant?_____ Currently breastfeeding?_____

Have you been losing weight? ☐ Yes ☐ No If yes, how much? _____ Over how long? _____

PLEASE LIST ALL MAJOR INJURIES / SURGERIES / ACCIDENTS

_____ _____

_____ _____

_____ _____

PLEASE LIST ALL CURRENT MEDICATIONS

PRESCRIBED:

_____ _____ _____

_____ _____ _____

OVER THE COUNTER:

_____ _____ _____

_____ _____ _____

Are you currently on probation or parole? ☐ Yes ☐ No

Do you have a pending cannabis case? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No How much/how often? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____ How often? _____

Do you use illicit drugs? ☐ Yes ☐ No