

PATIENT INFORMATION

Name _____ Date _____ Age _____

Medical history (Check if you have any of the following problems, please include approximate date of onset)

- | | |
|--|---|
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer/type | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Colon disorders or diverticulitis | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Deep venous thrombosis | <input type="checkbox"/> Myocardial infarction (Heart Attack) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neuropathy (Numbness in feet) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Gastric reflux or Peptic ulcers | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Vascular disease (legs or carotids) |

Please list any other medical problems not included above:

Surgical History (please check if you have had any of the following and list date)

- | | |
|--|--|
| <input type="checkbox"/> Aneurysm repair | <input type="checkbox"/> Hernia repair |
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> Hip replacement |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Lung removal |
| <input type="checkbox"/> Carotid artery surgery | <input type="checkbox"/> Knee replacement |
| <input type="checkbox"/> Cataract surgery | <input type="checkbox"/> Mastectomy or breast lump removal |
| <input type="checkbox"/> Colectomy | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Coronary bypass surgery | <input type="checkbox"/> Stent placement |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Gallbladder removal | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Heart valve replacement | |

Please list any surgeries not listed above:

Symptoms Review (circle all that apply):

General

fevers or chills
weight gain or loss
fatigue or weakness

Head, Eyes, ENT

headaches/migraines
blurring or double vision
nasal congestion
hearing loss
ringing in ears
vertigo
sore throat or
hoarseness
dentures or partials

Respiratory

chronic cough
phlegm production
wheezing
pleurisy or pneumonia

Endocrine

heat or cold intolerance
excess thirst or urination

Cardiovascular

chest pain or pressure
shortness of breath with
exertion
awaken short of breath
leg swelling
palpitations
lightheaded or black out
heart murmur

Gastrointestinal

abdominal pain
difficulty swallowing
heartburn
nausea or vomiting
vomiting blood
rectal bleeding
black stools
constipation or diarrhea
Irritable bowel

Neurological

limb weakness
speech difficulty
numbness of extremities
balance problems

Genitourinary

painful urination
frequent or urgent urination
frequent urination at night
bloody urine
bladder infections

Musculoskeletal

joint pain or stiffness
muscle pains
low back pain

Hematological

anemia
easy bruising or bleeding

Psychiatric

depression
anxiety
sleep disorder

Skin

rash
hives

| Medication | Dosage | Frequency | Medication | Dosage | Frequency |
|------------|--------|-----------|------------|--------|-----------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Previously used medications: _____

Allergies: _____

Family History

| | Age now or at death | Alive? | Health condition / Cause of death |
|----------------|---------------------|----------|-----------------------------------|
| Father | _____ | Yes / No | _____ |
| Mother | _____ | Yes / No | _____ |
| Brother/Sister | _____ | Yes / No | _____ |
| Brother/Sister | _____ | Yes / No | _____ |
| Brother/Sister | _____ | Yes / No | _____ |
| Son/Daughter | _____ | Yes / No | _____ |
| Son/Daughter | _____ | Yes / No | _____ |
| Son/Daughter | _____ | Yes / No | _____ |

Is there coronary disease in the family? (e.g. Angina, Angioplasty, Heart attack or Bypass) Yes _____ (please describe below) No _____

| | | |
|----------------|-----------|---------------|
| Relative _____ | Age _____ | Problem _____ |
| Relative _____ | Age _____ | Problem _____ |
| Relative _____ | Age _____ | Problem _____ |

Social History

Alcohol intake: _____ drinks per day / week / month / year (circle one)

Marital status (circle one): Single Married Divorced Widowed

Current or prior occupation: _____ Retired? Yes / No

Caffeine intake: coffee / tea / cola (circle) _____ times a day

Smoking history: never / stopped (year _____) / currently smoking

Regular Exercise? Type _____ Frequency _____

Physicians:

List any physicians you see routinely: _____

Signature _____

Date _____