NAME:		AGE:		TODAY'S DATE:	

WHAT PROBLEM(S) BRINGS YOU HERE TODAY?

WHO SENT YOU TO US?

DOCTOR / OTHER _____

WHICH DOCTOR?

WHAT SURGERY HAVE YOU HAD? (LIST)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7.

WHY HAVE YOU BEEN HOSPITALIZED? (OTHER THAN SURGERY)

LIST:

1. _____
2
3.
4.

HAVE YOU EVER HAD?

DIABETES	YES NO
HEART PROBLEMS	YES NO
HEART ATTACK	YES NO
ANGINA IN PAST MONTH	YES NO
STROKE	YES NO
HIGH BLOOD PRESSURE	YES NO
CARDIAC CATHETERIZATION	YES NO
HIGH CHOLESTEROL	YES NO
HEPATITIS/HIV/AIDS (CIRCLE ONE)	YES NO
KIDNEY FAILURE	YES NO
CANCER	YES NO
ARE YOU PREGNANT	YES NO
BIRTH CONTROL	YES NO
PACEMAKER	YES NO
AUTOMATIC DEFIBRILLATOR	YES NO

OTHER SERIOUS DISEASES - LIST:

_____

_____

_____

_____

WHAT MEDICATIONS ARE YOU ALLERGIC TO?

_____

_____

NAMES & DOSE OF KNOWN MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

DO YOU TAKE A STATIN?	YES NO
DO YOU TAKE COUMADIN?	YES NO
DO YOU TAKE PREDNISONE?	YES NO
DO YOU TAKE ASPIRIN?	YES NO
DO YOU TAKE PLAVIX?	YES NO

LIST YOUR FAMILY MEDICAL PROBLEMS

FATHER: _____

_____

MOTHER: _____

_____

BROTHERS: _____

_____

SISTERS: _____

_____

SONS: _____

_____

DAUGHTERS: _____

_____

PERSONAL HISTORY:

DO YOU SMOKE?	YES NO
HAVE YOU EVER SMOKED?	YES NO

WHEN DID YOU STOP? _____

HOW MUCH DO YOU DRINK? _____

DOCTOR SIGNATURE:

PATIENT SIGNATURE:

DATED:

DO YOU HAVE ANY OF THESE PROBLEMS? (***PLEASE CIRCLE***)

CARDIOVASCULAR:

Chest Pain in Past 6 Months **YES NO**
Angina in Past 6 Months **YES NO**
Shortness of Breath With Walking **YES NO**
Shortness of Breath Lying Down **YES NO**
Heart Failure **YES NO**
Heart Murmur **YES NO**
Irregular Heartbeat **YES NO**
Swelling of Feet or Legs **YES NO**
Leg Pain with Walking **YES NO**

NEUROLOGIC:

Stroke **YES NO**
Mini-Stroke or TIA **YES NO**
Sciatica **YES NO**
Fainting Spells **YES NO**
Seizures **YES NO**
Back Injury **YES NO**

NEUROPATHY:

Numbness in Legs **YES NO**
Pins and Needles Hands **YES NO**
Pins and Needles Feet **YES NO**

GENITO-URINARY:

Pain on Urination **YES NO**
Impotence **YES NO**
Frequent Urinating **YES NO**
Do You Have Blood In Urine Now **YES NO**
Frequent Urinary Tract Infection **YES NO**

ENDOCRINE:

Gout **YES NO**
Overactive Thyroid **YES NO**
Underactive Thyroid **YES NO**
Diabetes **YES NO**

INTEGUMENTARY (SKIN DISORDERS)/AUTO IMMUNE:

Rashes, Eczema, Psoriasis **CIRCLE ONE**
Lupus, Scleroderma, Sjogrens **CIRCLE ONE**
Melanoma **YES NO**
Basal Cell/Squamous Cell **CIRCLE ONE**

MUSCULOSKELETAL:

Osteoporosis **YES NO**
Rheumatoid Arthritis, Inflammatory Arthritis **YES NO**
Osteoarthritis **YES NO**

GASTROINTESTINAL:

Stomach Ulcer **YES NO**
Vomiting Blood **YES NO**
Hiatus Hernia **YES NO**
Heartburn or Indigestion **YES NO**
Gallbladder Disease **YES NO**
Liver Trouble **YES NO**
Black Stools **YES NO**
Recent Change In Bowel Habits **YES NO**
Bleeding with Bowel Movements **YES NO**
Hemorrhoids **YES NO**
Frequent Diarrhea **YES NO**
Abdominal Pain **YES NO**
Weight Change Past 6 Months **YES NO**
What change? _____

HEAD-EARS-EYES-NOSE-THROAT:

Chronic Sinus Trouble **YES NO**
Impaired Hearing **YES NO**
Dizziness **YES NO**
Temporary Spells of Blindness **YES NO**
Double Vision **YES NO**
Glaucoma **YES NO**
Cataracts **YES NO**

RESPIRATORY:

Spitting Up Blood **YES NO**
Chronic or Frequent Cough **YES NO**
Emphysema **YES NO**
Pneumonia **YES NO**
Recent Upper Respiratory Infection **YES NO**
Recent Flu Symptoms **YES NO**
Asthma **YES NO**

BLOOD PROBLEMS AND BLEEDING:

Do You Heal Cuts Slowly **YES NO**
Anemia **YES NO**
Blood Disorder **YES NO**
Excessive Bleeding in Surgery **YES NO**
Abnormal Bruising or Bleeding Due to Blood Thinner Meds **YES NO**
Phlebitis or Blood Clots in **Veins** **YES NO**

PSYCHIATRIC:

Anxiety **YES NO**
Depression **YES NO**
Suicidal Ideation **YES NO**

PATIENT SIGNATURE: _____

DATED: _____