PATIENT INFORMATION

Name__________________________________ **Date**___________ **Age**______

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

- ☐ Aneurysm
- ☐ Arthritis
- ☐ Asthma or Emphysema
- ☐ Atrial fibrillation/Arrhythmia
- ☐ Cancer/type
- ☐ Cholesterol problems
- ☐ Colon disorders or diverticulitis
- ☐ Congestive Heart Failure
- ☐ Deep venous thrombosis (Blood clot)
- ☐ Depression or Anxiety Disorder
- ☐ Diabetes
- ☐ Gastric reflux or Peptic ulcers
- ☐ Glaucoma
- ☐ Gout
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease or stones
- ☐ Liver disease
- ☐ Mitral Valve Prolapse
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Neuropathy (Numbness in feet)
- ☐ Phen-Fen Use
- ☐ Prostate enlargement
- ☐ Seizures
- ☐ Stroke or TIA
- ☐ Vascular disease (legs or carotids)

Please list any other medical problems not included above:

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

- ☐ Aneurysm Repair
- ☐ Angiogram/ Heart Catheterization
- ☐ Appendectomy
- ☐ Breast biopsy or Augmentation
- ☐ C-Section
- ☐ Carotid artery Surgery
- ☐ Cataract Surgery
- ☐ Colectomy
- ☐ Coronary bypass Surgery
- ☐ Cosmetic Surgery
- ☐ Gallbladder Removal
- ☐ Heart valve replacement
- ☐ Hernia repair
- ☐ Hip replacement of repair
- ☐ Hysterectomy
- ☐ Lung Removal
- ☐ Knee Replacement or Repair
- ☐ Mastectomy or breast lump removal
- ☐ Prostate Surgery
- ☐ Stent placement/Location_________
- ☐ Tonsillectomy
- ☐ Vasectomy

Please list any surgeries not listed above:

____

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____

Symptoms Review (circle all that apply):

General
fevers or chills
weight gain or loss
fatigue or weakness

Head, Eyes, ENT
headaches/migraines
glasses / contacts / LASIK
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
leg pain or cramping with walking
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
manic-depressive
schizophrenia

Skin
Rash
Hives

Medication	**Dosage**	**Frequency**	**Medication**	**Dosage**	**Frequency**
___________	_______	__________	___________	________	__________
___________	_______	__________	___________	________	__________
___________	_______	__________	___________	________	__________
___________	_______	__________	___________	________	__________
___________	_______	__________	___________	________	__________

Previously used medications:____

Allergies: ____

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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** ____________