



Patient Name _____ Date of Appointment _____ Date of Birth _____

Primary Care Physician _____

Reason for Today's Visit: (Please Print)

Current Medications: (Prescriptions, over the counter medications, vitamins and herbs)

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Medication _____ Dosage _____ Times per Day _____

Drug Allergies: _____ Reaction: _____

Medical History (Check all that apply)

Cardiovascular:

___ Coronary Artery Disease (Blocked Coronary Arteries)

___ Heart Attack

Angioplasty/Stent: When: _____ Where: _____

___ Coronary Artery Bypass Surgery

When: _____ Where: _____

___ Heart Valve Disease

___ Valve Replacement Surgery

When: _____ Where: _____

___ Arrhythmia (Irregular Heart Beat)

___ Atrial Fibrillation

___ Arterial Vascular Disease

___ Blood Clots in the legs (DVT)

Angioplasty/Stent: When: _____ Where: _____

___ Vascular Surgery

When: _____ Where: _____

___ Carotid Artery Disease

___ CVA (Stroke)-----When: _____

___ TIA (Mini Stroke)-----When: _____

Angioplasty/Stent: When: _____ Where: _____

___ Carotid Artery Surgery

When: _____ Where: _____

___ Congestive Heart Failure

___ Hypertension (High Blood Pressure)

___ High Cholesterol

___ High Triglycerides

___ Chest Pain/Pressure

___ Jaw Ache

___ Arm Ache

___ Palpitations

___ Heart fluttering

___ Heart Racing

___ Leg Cramps

- Numbness in limbs
- Lightheaded/Dizziness
- Fainting
- Leg Swelling

(Cardiovascular Cont'd)

- Abdominal Swelling
- Leg pain with walking
- Heart Murmur

Respiratory:

- Lung Disease
- COPD
- Emphysema
- Chronic Bronchitis
- Asthma
- History of Tuberculosis
- History of Pneumonia
- Sleep Apnea
- Shortness of Breath
- Excessive Sputum
- Cough
- Seasonal Allergies
- Snoring

Endocrine:

- Diabetes Mellitus
- Hypothyroidism
- Hyperthyroidism
- Heat Intolerance
- Cold Intolerance
- Hair Loss

Gastrointestinal:

- Gastric Reflux (GERD)
- Hiatal Hernia
- Ulcer
- Bowel/Intestinal Disorder
- Hepatitis
- Cirrhosis of the Liver
- GI Bleeding
- Constipation
- Diarrhea

Hematological:

- Coumadin Therapy
- Bleeding disorders
- Easy Bleeding
- Easy Bruising
- Anemia
- Blood Transfusion

- HIV/AIDS

Genitourinary:

- Enlarged Prostate
- Prostate Cancer
- Erectile Dysfunction
- Bladder Cancer
- Urinary Incontinence
- Difficulty urinating

Neurological:

- Seizures
- Alzheimer's Dementia
- Dementia
- Migraine Headaches
- Memory Problems

Musculoskeletal:

- Arthritis
- Rheumatoid Arthritis
- Osteoarthritis
- Osteoporosis
- Joint Pain
- Muscle Aches
- Gout

Oncology:

Psychiatric:

- Depression
- Anxiety
- Nervousness
- Difficulty Sleeping

Women's Health:

- Menopausal
- Post- menopausal
- Pregnant

HEENT:

- Sinus Problems
- Headaches
- Visual Changes
- Hearing Loss

Skin:

- Rash
- Lesions

General:

Weight Changes in Last 6 Months:

Weight Gain: _____ lbs.

Weight Loss: _____ lbs.

Other: (Not listed above)

Social History:

Tobacco: ___ Never ___ Former ___ Current

Amount: _____ Quit Date: _____

Alcohol: ___ Never ___ Former ___ Current

Amount _____

Caffeine: ___ None ___ Current: Amount _____

Exercise:

Type of Exercise: _____

Frequency: _____

Occupation: _____

Married/ Single/ Widowed _____

Children: _____

Surgical History:

1. Type of Surgery _____

Date _____ by Dr. _____

2. Type of Surgery _____

Date _____ by Dr. _____

3. Type of Surgery _____

Date _____ by Dr. _____

4. Type of Surgery _____

Date _____ by Dr. _____

5. Type of Surgery _____

Date _____ by Dr. _____

Family History:

List immediate family members with any of the following:

Heart Attack, Heart Blockage, Angioplasty, Heart Bypass Surgery, High Blood Pressure, High Cholesterol, Diabetes, Stroke or Congestive Heart Failure.

Relative:	Medical Conditions:	Living?	Age at
*		*	
*		*	*
*		*	*
*		*	*
*		*	*