All questions are strictly confidential and will become part of your medical record. **Today's Date:** _____

PATIENT MEDICAL HISTORY

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	

Referring Doctor(s):

List the other doctors involved in your care:

Describe present problem(s) or symptoms:

PLEASE CHECK ANY PAST OR CURRENT PROBLEMS:

☐ Atrial Fibrillation	☐ Circulation problems	☐ Heart Stents	☐ Liver Disease	☐ Seizures
☐ Anemia	☐ Carotid Disease	☐ Hepatitis	☐ Pacemaker	☐ Sleep Apnea
☐ Aortic Aneurysm	☐ Cirrhosis	☐ High Cholesterol	☐ Chronic pain	☐ Stroke
☐ Asthma/emphysema	☐ Diabetes	☐ High blood pressure	☐ Peripheral Artery Disease	☐ Stomach ulcers
☐ Auto Immune Dis.	☐ Dialysis/kidney failure	☐ Irregular Heart Rate	☐ Phlebitis (vein clots)	☐ Thyroid Disorder
☐ Bleeding problems	☐ Heart Attack	☐ Kidney Disease	☐ Pneumonia	☐ Tuberculosis
☐ Blood clots	☐ Heart Failure			

☐ Implants/surgical or other metal inside the body: type: location:

☐ Cancer / Type: Other Health Problems / Specify:

☐ **Problems with anesthesia, please describe:**

PLEASE LIST ANY SURGERIES OR MAJOR HOSPITALIZATIONS:

Year	Reason	Hospital

PLEASE LIST MEDICATIONS AND DOSE YOU ARE CURRENTLY TAKING:

ALLERGY	**REACTION:**	**ALLERGY**	**REACTION:**

PLEASE TURN PAGE AND COMPLETE SIDE-TWO

HEALTH HABITS AND PERSONAL INFORMATION

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)	☐ Mild exercise	☐ Occasional vigorous exercise	☐ Regular vigorous exercise	
Diet	Are you on a special diet?				
Marital Status:	**Number of children:**	**Occupation:**	**Retired:**	☐ Yes	☐ No
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	# of cups/cans per day?
Alcohol	Do you drink alcohol? If yes, how may drinks per week? _____			☐ Yes	☐ No
Tobacco	Do you use tobacco? ☐ Yes ☐ No	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ # of years	
Drugs	Do you currently use recreational or street drugs? If yes, type _____			☐ Yes	☐ No

FAMILY HEALTH HISTORY

Have you had a family member with any of the following? If so, please check the appropriate box.

	Father	Mother	Children	Brother/ Sister	Maternal & Paternal Grandparents			Father	Mother	Children	Brother/ Sister	Maternal & Paternal Grandparents	
Aneurysm	☐	☐	☐	☐	M ☐	P ☐	High Blood Pressure	☐	☐	☐	☐	M ☐	P ☐
Asthma/Emphysema	☐	☐	☐	☐	M ☐	P ☐	Kidney Disease	☐	☐	☐	☐	M ☐	P ☐
Cancer	☐	☐	☐	☐	M ☐	P ☐	Stroke	☐	☐	☐	☐	M ☐	P ☐
Diabetes	☐	☐	☐	☐	M ☐	P ☐	Lung Disease	☐	☐	☐	☐	M ☐	P ☐
Heart Disease	☐	☐	☐	☐	M ☐	P ☐		☐	☐	☐	☐	M ☐	P ☐

REVIEW OF SYSTEMS

Circle items that apply to you now. . . How are you feeling <u>now</u>?

Constitutional:	Fever, chills, weight loss, fatigue, loss of appetite, body aches, night sweats
Eyes:	Changes in vision, blurred vision,, double vision
Ears, Nose, Throat:	Headaches, loss of hearing, dizziness, nose bleeding
Breasts:	Lumps, tenderness, swelling, nipple discharge
Cardiovascular:	Chest pain, murmurs, irregular heart beats, rapid heart rate, foot pain at rest/activity
Respiratory:	Shortness of breath, wheezing, cough, sleep apnea, problems with anesthesia
Gastrointestinal:	Loss of appetite, heartburn, difficulty swallowing, nausea/vomiting, abdominal pain, blood in stools, constipation
Urinary:	Urgency, frequency, incontinence, blood in urine
Skin:	Rash, itching, new skin lesions, hair growth change, nail change
Neurological:	Tingling or numbness, poor balance, difficulty concentrating, memory or speech difficulties, seizures
Musculoskeletal:	Bone/back/joint pain, muscle pain, joint swelling, muscle weakness, muscle cramps
Endocrine:	Excessive eating or drinking, loss of hair, cold/heat intolerance, weight gain or weight loss, hot flashes
Hematology:	Easy bleeding, easy bruising, lymph node pain or enlargement, lightheadedness

ACKNOWLEDGMENTS

I understand that all the above may not be addressed at this office visit. Be sure your family doctor is aware of your current symptoms. Patient Signature:

Physician reviewed. Date and signature: