



PLEASE FILL OUT ALL PAGES AS COMPLETELY AS POSSIBLE.

Name _____ Date of Birth _____ Age _____
 Date _____ Referring Physician _____

CHIEF COMPLAINTS:

PAST MEDICAL HISTORY (HAVE YOU HAD THESE?)

CARDIAC:

Coronary Artery Disease YES ___ NO ___
 Heart Attack YES ___ NO ___
 Coronary Artery Stent YES ___ NO ___
 Heart Catheterization YES ___ NO ___
 Heart Bypass Surgery YES ___ NO ___
 Hypertension YES ___ NO ___
 Congestive Heart Failure YES ___ NO ___

ENDOCRINE:

Diabetes YES ___ NO ___
 High Cholesterol YES ___ NO ___
 Hypothyroidism YES ___ NO ___
 Hyperthyroidism YES ___ NO ___

NEUROLOGICAL:

Stroke YES ___ NO ___
 Epilepsy YES ___ NO ___

VASCULAR:

Peripheral Vascular Disease YES ___ NO ___
 Carotid Artery Disease YES ___ NO ___
 Varicose Veins YES ___ NO ___

RESPIRATORY:

Bronchial Asthma YES ___ NO ___
 Pneumonia YES ___ NO ___
 Emphysema YES ___ NO ___
 Lung Cancer YES ___ NO ___
 Sleep Apnea YES ___ NO ___

GASTRINTESTINAL:

Peptic Ulcer Disease YES ___ NO ___
 Hepatitis YES ___ NO ___
 Irritable Bowel Syndrome YES ___ NO ___
 Ulcerative Colitis YES ___ NO ___
 Crohn's Disease YES ___ NO ___

UROLOGICAL:

Kidney Stones YES ___ NO ___
 Chronic Kidney Disease YES ___ NO ___
 Benign Prostatic Hypertrophy YES ___ NO ___

OTHERS:

Arthritis YES ___ NO ___
 Bleeding Disorders YES ___ NO ___
 Cancer YES ___ NO ___

LIST ANY OTHER DISEASES:

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES WITH APPROXIMATE DATES:

ALLERGIES (TO THE FOLLOWING MEDICATIONS, PLEASE CHECK)

PENICILLIN _____ SULFA _____ ASPRIN _____ SHELLFISH _____ IV DYE _____

OTHER MEDICATIONS:

PLEASE SPECIFY REACTION TO ABOVE MEDICATIONS: _____

CURRENT MEDICATIONS

Name	Dose	Frequency	Name	Dose	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

FAMILY MEDICAL HISTORY (Has any blood relative ever had?)

	YES	NO	WHO		YES	NO	WHO
Diabetes	_____	_____	_____	Cancer	_____	_____	_____
High Blood Pressure	_____	_____	_____	Stroke	_____	_____	_____
Heart Disease	_____	_____	_____	Abnormal Bleeding	_____	_____	_____

SOCIAL HISTORY

Female Patients: Are you pregnant or do you think you are pregnant? YES _____ NO _____

Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

TOBACCO USE

Are you currently using tobacco? YES _____ NO _____ #packs per day _____ for how many years _____

How long after you wake up do you smoke your first cigarette? _____

How ready you are to quit? (check one) _____ Ready to quit? _____ Thinking about quitting? _____

Not ready to quit? Did you use tobacco in the past? YES _____ NO _____ # packs per day _____ for how many years _____

Date you quit _____

ALCOHOL USE

Do you use alcohol regularly? YES _____ NO _____ How much per day for how many years? Did you use tobacco in the past? YES _____ NO _____ How much per day for how many? _____ Date you quit _____

Exercise

Do you exercise regularly? YES _____ NO _____ How much? _____

REVIEW OF SYSTEMS

CARDIAC:

Shortness of Breath YES ___ NO ___
Chest Pain YES ___ NO ___
Heart Palpitations YES ___ NO ___
Dizziness, Fainting YES ___ NO ___
Ankle Swelling YES ___ NO ___

ENDOCRINE:

Excessive Thirst YES ___ NO ___
Increased Urination YES ___ NO ___
Heat or Cold Intolerance YES ___ NO ___
Rising to void, more than
once per night YES ___ NO ___

NEUROLOGICAL:

Severe Headaches YES ___ NO ___
Confusion YES ___ NO ___
Weakness in Arm/Leg YES ___ NO ___
Transient Blindness YES ___ NO ___

VASCULAR:

Calf Pain on Ambulation YES ___ NO ___
Numbness/ Tingling in Feet YES ___ NO ___

RESPIRATORY:

Cough YES ___ NO ___
Spitting of Blood YES ___ NO ___
Wheezing YES ___ NO ___

GASTROINTESTINAL:

Abdominal Pain or Heartburn YES ___ NO ___
Nausea, Vomiting YES ___ NO ___
Diarrhea YES ___ NO ___
Constipation YES ___ NO ___

GENERAL REVIEW:

Weight Change YES ___ NO ___
Extreme Fatigue YES ___ NO ___
Fever YES ___ NO ___
Joint Pains YES ___ NO ___
Excessive Bruising YES ___ NO ___
Impaired Sight YES ___ NO ___
Nose Bleed YES ___ NO ___
Anxiety YES ___ NO ___