Patient Name: _____ **Date of Birth:** _____

Reason for today's visit:

_____

_____

_____

_____

Past Medical History		Past Surgical History	
High Blood Pressure	☐ No ☐ Yes	Coronary Bypass	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Heart Valve Surgery	☐ No ☐ Yes
High Cholesterol	☐ No ☐ Yes	Pacemaker/Defibrillator	☐ No ☐ Yes
Congestive Heart Failure	☐ No ☐ Yes	Stents/Angioplasty	☐ No ☐ Yes
Chronic Obstructive Pulmonary Disease	☐ No ☐ Yes	Other: _____	
Other: _____		Other: _____	

ALLERGIES

Please list all medication, food, environmental, and other allergies:

FAMILY HISTORY : If you know of any blood relatives who have or have had significant medical conditions, please list the condition and relationship below.

Relative	Age	Sex	Medical Problems	Age at Death	Cause
Father					
Mother					
Brother					
Sister					

Patient Name: _____ **Date of Birth:** _____

MEDICATIONS

Please provide below or bring a current list of all prescription and non-prescription medications, vitamins, and supplements prior to your appointment.

	Medication Name	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			

HEALTH HABITS

	No	Yes	Amount	How Long	Year Stopped
Tobacco Use					
Alcohol Use					
Illicit Drug Use					
Coffee Use					
Tea Use					
Soft Drinks					

EXERCISE

Activity	No	Yes	Type / Location	List how often within a week
Exercise Regularly				
Walking			☐ Indoor ☐ Outdoor	
Running/Jogging			☐ Indoor ☐ Outdoor	
Strength Training				
Stretching/Yoga				
Physical Therapy				

Patient Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS

Have you **recently** experienced any of the following? Please check all that apply.

Cardiovascular	Respiratory	Neurological	Constitutional	Gastrointestinal
☐ Chest Pain ☐ High Blood Pressure ☐ Controlled ☐ Uncontrolled ☐ Varicose Veins ☐ Swelling in Ankles/Feet	☐ Wheezing ☐ Cough ☐ Shortness of Breath ☐ With Exertion ☐ Asthma ☐ Emphysema	☐ Tremors ☐ Dizziness ☐ Numbness ☐ Arm/Leg Weakness	☐ Fever ☐ Chills ☐ Headache ☐ Major Weight Change ☐ Appetite Loss ☐ Snoring ☐ Stop Breathing During Sleep ☐ Sleep on More Than One Pillow	☐ Abdominal Pain ☐ Diarrhea ☐ Constipation ☐ Nausea/Vomiting ☐ Heartburn ☐ Mucous in Stool ☐ Blood in Stool ☐ Ribbon-Like Stool
Genitourinary	**Ears / Eyes / Throat**	**Musculoskeletal**	**Eyes**	**Skin**
☐ Difficulty Urinating ☐ Painful Urination ☐ Frequent Urination ☐ Blood in Urine ☐ Urinate More Than Twice at Night ☐ Difficulty with Erections	☐ Ear Infection ☐ Sore Throat ☐ Sinus Problems ☐ Difficulty Swallowing ☐ Hoarseness	☐ Joint Pain ☐ Neck Pain ☐ Back Pain ☐ Leg/Hip Pain When Walking	☐ Blurred Vision ☐ Double Vision ☐ Eye Pain ☐ Cataracts ☐ Glaucoma	☐ Rash ☐ Itching ☐ Ulcers on Feet ☐ Hair Loss
Hematologic / Lymphatic	**Allergy / Immunology**	**Psychological**	**Endocrine**	
☐ Swollen Glands ☐ Blood Clotting Problems ☐ Unexplained Bruising	☐ Allergies ☐ Hay Fever	☐ Depression ☐ Anxiety ☐ Unusual Stress ☐ Eating Disorder ☐ Attempted Suicide	☐ Thyroid Problems ☐ Hot Flashes ☐ Cold Intolerance	

OTHER SYMPTOMS OR COMMENTS: