NAME: ____________________ D/O/B: _______ DATE: ____________ MR#__________

WHAT PROBLEM(S) BRINGS YOU HERE TODAY?

WHO SENT YOU TO US?
DOCTOR/OTHER _________________
WHICH DOCTOR? ________________

WHAT SURGERY HAVE YOU HAD AND WHEN? (LIST)
1.________________________
2.________________________
3.________________________
4.________________________
5.________________________
6.________________________
7.________________________

HOW MUCH ALCOHOL DO YOU DRINK APPROXIMATELY? _____DAY ______WEEK _____MONTH

DO YOU SMOKE? YES NO

HAVE YOU EVER SMOKED? YES NO

WHEN DID YOU STOP? ____________

ILLEGAL DRUG USE? PAST/ PRESENT/ NONE

OCCUPATION (CURRENTLY/ BEFORE RETIRED) ______________

LIST YOUR FAMILY MEDICAL PROBLEMS:

	CIRCLE ONE:	AGE(S) NOW/ AT TIME OF DEATH:	MAJOR ILLNESS/CAUSE OF DEATH:
MOTHER:	LIVING / DECEASED	_____	________________ ________________ ________________
FATHER:	LIVING / DECEASED	_____	________________ ________________ ________________
SIBILINGS:	LIVING / DECEASED	_____	________________ ________________ ________________
CHILDREN:	LIVING / DECEASED	_____	________________ ________________ ________________

ANY FAMILY HISTORY OF ANEURYSM OR DVT? YES NO

HAVE YOU EVER HAD ANY OF THE FOLLOWING LISTED BELOW IN *THE PAST*?

VASCULAR:	
Aneurysm	**YES NO**
Deep Vein Thrombosis (DVT)	**YES NO**
Pulmonary Embolus	**YES NO**
Carotid Disease	**YES NO**
Leg Swelling	**YES NO**
Varicose Veins	**YES NO**
Spider Veins	**YES NO**
Treatment of Varicose Veins	**YES NO**
Gangrene	**YES NO**
Stroke	**YES NO**
Vascular Problems	**YES NO**

CARDIAC:	
Heart Problems	**YES NO**
Heart Attack	**YES NO**
High Cholesterol	**YES NO**
Pacemaker	**YES NO**
Automatic Defibrillator	**YES NO**
Rhythm Problems	**YES NO**
High Blood Pressure	**YES NO**
Heart Murmur	**YES NO**

PULMONARY:	
Asthma	**YES NO**
Bronchitis	**YES NO**
COPD (Emphysema)	**YES NO**
Lung Cancer	**YES NO**
Pneumonia	**YES NO**
Sleep Apnea	**YES NO**

GASTROINTESTINAL:	
Bleeding	**YES NO**
Hepatitis	**YES NO**
Reflux	**YES NO**
Gallbladder Disease	**YES NO**
Colon Polyps	**YES NO**
Inflammatory Bowel	**YES NO**
Ulcer	**YES NO**
Irritable Bowel Disease	**YES NO**
Other	______________

GU:	
Prostate Cancer	**YES NO**
Kidney Stones	**YES NO**
Kidney Failure	**YES NO**
BPH	**YES NO**

ENDOCRINE:

Gout	**YES NO**
Overactive Thyroid	**YES NO**
Underactive Thyroid	**YES NO**
Diabetes	**YES NO**
Other	____________

GYN:

Cervical Cancer	**YES NO**
Hysterectomy	**YES NO**
Other	____________

NEUROLOGIC:

Stroke	**YES NO**
Mini-Stroke or TIA	**YES NO**
Arm or Leg Weakness	**YES NO**
Episode of loss of vision	**YES NO**
Difficulty Speaking	**YES NO**
Sciatica	**YES NO**
Fainting spells	**YES NO**
Seizures	**YES NO**
Back injury	**YES NO**
Headaches	**YES NO**
Other	____________

MUSCULOSKELETAL:

Osteoporosis	**YES NO**
Rheumatoid/Inflammatory Arthritis	**YES NO**
Osteoarthritis	**YES NO**
History of fracture	**YES NO**
Fibromyalgia	**YES NO**
Polymyalgia Rheumatic (PMR)	**YES NO**

BLOOD PROBLEMS AND BLEEDING:

Do you heal cuts slowly	**YES NO**	
Anemia	**YES NO**	**WHEN?________**
Blood Disorder	**YES NO**	
Excessive bleeding in surgery	**YES NO**	
Abnormal bruising or bleeding due to blood thinner meds	**YES NO**	
Phlebitis or blood clots in veins	**YES NO**	
Other	____________	

INTEGUMENTARY (SKIN DISORDERS)/AUTO IMMUNE - Circle one below:

Rashes, Eczema, Psoriasis	**Melanoma**	**YES NO**
Lupus, Scleroderma, Sjogrens		
Basal Cell/Squamous Cell		

PSYCHIATRIC:

Anxiety	**YES NO**
Depression	**YES NO**
Suicidal Ideation	**YES NO**

OTHER:	
Cataracts	**YES NO**
Glaucoma	**YES NO**

WHAT MEDICATIONS ARE YOU ALLERGIC TO?

____
____
____

ARE YOU ON A BLOOD THINNER?	**YES NO**
DO YOU TAKE A STATIN?	**YES NO**
DO YOU TAKE COUMADIN?	**YES NO**
DO YOU TAKE PREDNISONE?	**YES NO**
DO YOU TAKE ASPIRIN?	**YES NO**
DO YOU TAKE PLAVIX?	**YES NO**

NAMES & DOSE OF KNOWN MEDICATIONS:

1.__________________________
2.__________________________
3.__________________________
4.__________________________
5.__________________________
6.__________________________

RECENT SYMPTOMS IN THE LAST 6 MONTHS?

Fever/Chills	**YES NO**
Weight change in the past 6 months	**YES NO**
Fatigue	**YES NO**
Other?	________________

ARE YOU PREGNANT?	**YES NO**
ARE YOU ON BIRTH CONTROL?	**YES NO**

Impaired Hearing	**YES NO**
Dizziness	**YES NO**
Temporary spells of blindness	**YES NO**
Double Vision	**YES NO**

NEUROLOGIC:	
Arm or Leg Weakness or Paralysis	**YES NO**
Difficulty Speaking	**YES NO**
Loss of vision in one eye	**YES NO**
Poor balance	**YES NO**
Headaches	**YES NO**
Sciatica	**YES NO**
Fainting spells	**YES NO**
Seizures	**YES NO**
Back injury	**YES NO**

NEUROPATHY:	
Numbness in legs	**YES NO**
Pins and Needles Hands	**YES NO**
Pins and Needles Feet	**YES NO**

CARDIOVASCULAR:	
Chest pain in past 6 months	**YES NO**
Angina in past 6 months	**YES NO**
Shortness of breath with walking	**YES NO**
Shortness of breath lying down	**YES NO**
Heart failure	**YES NO**
Irregular heartbeat	**YES NO**

RESPIRATORY:	
Spitting up blood	**YES NO**
Chronic or frequent cough	**YES NO**
Shortness of breath	**YES NO**
Chest congestion	**YES NO**
Recent upper respiratory infection	**YES NO**
Recent flu symptoms	**YES NO**
Wheezing	**YES NO**
Sleep Apnea	**YES NO**

VASCULAR:	
Swelling of feet or legs	**YES NO**
Leg pain with walking	**YES NO**
Pain in feet at night	**YES NO**
Wounds on legs/feet	**YES NO**
Varicose Veins	**YES NO**
Skin color change	**YES NO**
Gangrene	**YES NO**

SKIN:	
Itching	**YES NO**
Rashes	**YES NO**
Wound	**YES NO**
Lesions	**YES NO**

GASTROINTESTINAL:	
Stomach ulcer	**YES NO**
Vomiting blood	**YES NO**
Hiatus hernia	**YES NO**
Heartburn or Indigestion	**YES NO**
Gallbladder disease	**YES NO**
Liver trouble	**YES NO**
Black stools	**YES NO**
Recent change in bowel movements	**YES NO**
Bleeding with bowel movements	**YES NO**
Hemorrhoids	**YES NO**
Frequent diarrhea	**YES NO**
Abdominal Pain	**YES NO**

GENITO-URINARY:	
Pain on urination	**YES NO**
Impotence	**YES NO**
Frequent Urination	**YES NO**
Blood in urine now	**YES NO**
Frequent urinary tract infection	**YES NO**
Night time urination	**YES NO**

MUSCULOSKELETAL:	
Muscle Weakness	**YES NO**

Pain	**YES NO**
Joint Stiffness	**YES NO**
Joint Swelling	**YES NO**
Boney Aches	**YES NO**

HEMATOLOGIC:	
Anemia	**YES NO**
Blood disorder	**YES NO**
Cancer	**YES NO**

ENDOCRINE:	
Treatment of thyroids	**YES NO**
Diabetes	**YES NO**
Other	________________

PSYCHIATRIC:	
Depression	**YES NO**
Anxiety	**YES NO**

PATIENT SIGNATURE: ____________________

DATE: ____________