Patient Name: _____ **Gender:** _____

Birth Date: _____ **Rendering Physician:**_____

Appt Date: _____

Past Medical History

__Allergies	__Cancer	__Gall bladder disease	__Migraine headaches
__Anemia	__Circulation problems	__Reflux	__Osteoarthritis
__Angina	__Colitis	__Hepatitis B or C	__Osteoarthritis
__Anxiety	__COPD	__High blood pressure	__Seizure disorder
__Irregular heart beat	__Coronary artery disease	__High cholesterol	__Stomach/Duodenal ulcer
__Arthritis	__Crohn's disease	__Irritable bowel disease	__Thyroid disease
__Asthma	__Depression	__Liver disease	__Valve disease
__Prostatic hypertrophy	__Diabetes		

	Year		**Year**
__Atrial fibrillation	_____	__Heart attack	_____
__ Blood clots	_____	__Heart failure	_____
__CVA (stroke)	_____	__Kidney disease	_____

Past Surgical History	**Year**		**Year**		**Year**
__Angioplasty	_____	__Colostomy	_____	__LASIK	_____
__Stent	_____	__Weight loss surgery	_____	__Liver biopsy	_____
__Appendectomy	_____	__Gall bladder surgery	_____	__Lower extr vasc sx	_____
__Back surgery	_____	__Heart valve replac	_____	__Pacemaker	_____
__Bypass surgery	_____	__Hernia repair	_____	__Small bowel resec	_____
__Carpal tunnel rel	_____	__Hip surgery	_____	__Thyroidectomy	_____
__Cataract extraction	_____	__Knee surgery	_____	__Tonsillectomy	_____

Other Past Surgical History	**Year**	Breast surgery? What Type?	Cancer Surgery? What Type?
_____	_____	_____	_____

Family History

*Please indicate if your mother, father or sibling has any of the following diseases **now** or if it was their cause of death* (**COD**).

	Mother		Father		Sister(s)		Brother(s)	
	Now	*COD*	*Now*	*COD*	*Now*	*COD*	*Now*	*COD*
CVA (stroke)	__	__	__	__	__	__	__	__
Diabetes	__	__	__	__	__	__	__	__
Heart disease	__	__	__	__	__	__	__	__
Hrt disease before 60	__	__	__	__	__	__	__	__
Heart failure	__	__	__	__	__	__	__	__
High blood pressure	__	__	__	__	__	__	__	__
High cholesterol	__	__	__	__	__	__	__	__
Kidney disease	__	__	__	__	__	__	__	__

Please indicate if your mother, father or sibling has had any of the following diseases:

__Alcoholism __Asthma __Circulation problems __Irritable Bowel disease __Obesity
__Allergies __Blood disease __Depression __Mental illness __Seizures
__Alzheimer's __Cancer __Eczema __Migraines

Other family history: _____
_____

Social History

Marital status __Married __Single __Divorced __Widowed __Life partner
Race __White __African-American __Hispanic __Asian __Other_____
Language __English __Spanish __Chinese __French __Other_____
Ethnicity __Hispanic or Latino __Not Hispanic or Latino

What is your tobacco use history?

Uses tobacco __Currently __Never __Formerly
Tobacco type __Cigarettes __Chewing __Cigar __Pipe __Smokeless __Snuff
Amount per day _____ (packs, ounces, cigars, pipes, units) Number of years_____
Tobacco cessation discussed __Yes __No
Passive smoke exposure __Yes __No

What is your alcohol use history?

Drinks alcohol __Yes __No __Formerly
Frequency __Daily __Weekly __Monthly __Occasionally __Rarely
Drinks caffeine __Yes __No

Types of exercise (please choose up to three)

__Cycling __Jogging/Running __Tennis __Weights
__Golf __Swimming __Walking __Yoga __Other_____
Exercise frequency __2-3 times per week __3-4 times per week __Daily __Occasionally __Never

Review of Systems

Please check all appropriate boxes

Cardiac

Chest Pain __Yes __No
Excessive Perspiration __Yes __No
Palpitations __Yes __No
Fainting/Lightheaded __Yes __No
Shortness of Breath lying down __Yes __No
Wake up from sleep due to shortness of breath __Yes __No

Gastrointestinal

Nausea __Yes __No
Reflux __Yes __No
Blood in stool __Yes __No

Genitourinary

Blood in urine __Yes __No
Night urination __Yes __No
Painful urination __Yes __No

Endocrine

Goiter __Yes __No
Tremors __Yes __No

Dermatologic

Rash __Yes __No
Skin sores __Yes __No

Vascular

Leg pain when walking __Yes __No
Swelling in legs __Yes __No

Neurological

Dizziness __Yes __No
Memory loss __Yes __No
Seizures __Yes __No

Musculoskeletal

Joint pain __Yes __No
Muscle pain __Yes __No

Constitutional

Weight gain __Yes __No
Weight loss __Yes __No
Fever __Yes __No

Psychiatric

Depression __Yes __No
Hallucinations __Yes __No
Anxiety __Yes __No

HEENT

Vision changes __Yes __No
Hearing loss __Yes __No

Hematology

Anemia __Yes __No
Easy bruising __Yes __No

Respiratory

Snoring __Yes __No
Coughing up blood __Yes __No
Shortness of breath __Yes __No

Reproductive

Hx of oral contraceptives __Yes __No __N/A