

<b>NAME:</b> _____	<b>AGE:</b> _____	<b>TODAY'S DATE:</b> _____																																																															
<b>WHAT PROBLEM(S) BRINGS YOU HERE TODAY?</b>	<b>WHO SENT YOU TO US?</b> <b>DOCTOR / OTHER</b> _____ <b>WHICH DOCTOR?</b> _____																																																																
<b>WHAT SURGERY HAVE YOU HAD? (LIST)</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ <b>WHY HAVE YOU BEEN HOSPITALIZED? (OTHER THAN SURGERY)</b> <b>LIST:</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ <b>WHAT MEDICATIONS ARE YOU ALLERGIC TO?</b> _____ _____ <b>NAMES &amp; DOSE OF KNOWN MEDICATIONS:</b> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ <b>DOCTOR SIGNATURE:</b> _____	<b>HAVE YOU EVER HAD?</b> <table border="0"> <tr><td>DIABETES</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>HEART PROBLEMS</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>HEART ATTACK</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>ANGINA IN PAST MONTH</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>STROKE</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>HIGH BLOOD PRESSURE</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>CARDIAC CATHETERIZATION</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>HIGH CHOLESTEROL</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>HEPATITIS/HIV/AIDS (CIRCLE ONE)</td><td></td><td><u>NO</u></td></tr> <tr><td>KIDNEY FAILURE</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>CANCER</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>ARE YOU PREGNANT</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>BIRTH CONTROL</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>PACEMAKER</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>AUTOMATIC DEFIBRILLATOR</td><td><u>YES</u></td><td><u>NO</u></td></tr> </table> <b>OTHER SERIOUS DISEASES - LIST:</b> _____ _____ _____ _____  <table border="0"> <tr><td>DO YOU TAKE COUMADIN?</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>DO YOU TAKE PREDNISONE?</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>DO YOU TAKE ASPIRIN?</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>DO YOU TAKE PLAVIX?</td><td><u>YES</u></td><td><u>NO</u></td></tr> </table> <b>LIST YOUR FAMILY MEDICAL PROBLEMS</b> <b>MOTHER:</b> _____ _____ <b>FATHER:</b> _____ _____ <b>SIBLINGS?</b> _____ _____ <b>PERSONAL HISTORY:</b> <table border="0"> <tr><td>DO YOU SMOKE?</td><td><u>YES</u></td><td><u>NO</u></td></tr> <tr><td>HAVE YOU EVER SMOKED?</td><td><u>YES</u></td><td><u>NO</u></td></tr> </table> <b>WHEN DID YOU STOP?</b> _____ <b>HOW MUCH DO YOU DRINK?</b> _____		DIABETES	<u>YES</u>	<u>NO</u>	HEART PROBLEMS	<u>YES</u>	<u>NO</u>	HEART ATTACK	<u>YES</u>	<u>NO</u>	ANGINA IN PAST MONTH	<u>YES</u>	<u>NO</u>	STROKE	<u>YES</u>	<u>NO</u>	HIGH BLOOD PRESSURE	<u>YES</u>	<u>NO</u>	CARDIAC CATHETERIZATION	<u>YES</u>	<u>NO</u>	HIGH CHOLESTEROL	<u>YES</u>	<u>NO</u>	HEPATITIS/HIV/AIDS (CIRCLE ONE)		<u>NO</u>	KIDNEY FAILURE	<u>YES</u>	<u>NO</u>	CANCER	<u>YES</u>	<u>NO</u>	ARE YOU PREGNANT	<u>YES</u>	<u>NO</u>	BIRTH CONTROL	<u>YES</u>	<u>NO</u>	PACEMAKER	<u>YES</u>	<u>NO</u>	AUTOMATIC DEFIBRILLATOR	<u>YES</u>	<u>NO</u>	DO YOU TAKE COUMADIN?	<u>YES</u>	<u>NO</u>	DO YOU TAKE PREDNISONE?	<u>YES</u>	<u>NO</u>	DO YOU TAKE ASPIRIN?	<u>YES</u>	<u>NO</u>	DO YOU TAKE PLAVIX?	<u>YES</u>	<u>NO</u>	DO YOU SMOKE?	<u>YES</u>	<u>NO</u>	HAVE YOU EVER SMOKED?	<u>YES</u>	<u>NO</u>
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<b>DO YOU HAVE ANY OF THESE PROBLEMS?</b>	<b>(PLEASE CIRCLE)</b>
<p><b>CARDIOVASCULAR:</b></p> <p>Chest Pain in Past 6 Months _____ <b>YES</b> <b>NO</b></p> <p>Angina in Past 6 Months _____ <b>YES</b> <b>NO</b></p> <p>Shortness of Breath With Walking _____ <b>YES</b> <b>NO</b></p> <p>Shortness of Breath Lying Down _____ <b>YES</b> <b>NO</b></p> <p>Heart Failure _____ <b>YES</b> <b>NO</b></p> <p>Heart Murmur _____ <b>YES</b> <b>NO</b></p> <p>Irregular Heartbeat _____ <b>YES</b> <b>NO</b></p> <p>Swelling of Feet or Legs _____ <b>YES</b> <b>NO</b></p> <p>Leg Pain with Walking _____ <b>YES</b> <b>NO</b></p> <p><b>NEUROLOGIC:</b></p> <p>Stroke _____ <b>YES</b> <b>NO</b></p> <p>Mini-Stroke or TIA _____ <b>YES</b> <b>NO</b></p> <p>Sciatica _____ <b>YES</b> <b>NO</b></p> <p>Fainting Spells _____ <b>YES</b> <b>NO</b></p> <p>Seizures _____ <b>YES</b> <b>NO</b></p> <p>Back Injury _____ <b>YES</b> <b>NO</b></p> <p><b>NEUROPATHY:</b></p> <p>Numbness in Legs _____ <b>YES</b> <b>NO</b></p> <p>Pins and Needles Hands _____ <b>YES</b> <b>NO</b></p> <p>Pins and Needles Feet _____ <b>YES</b> <b>NO</b></p> <p><b>GENITO-URINARY:</b></p> <p>Pain on Urination _____ <b>YES</b> <b>NO</b></p> <p>Impotence _____ <b>YES</b> <b>NO</b></p> <p>Frequent Urinating _____ <b>YES</b> <b>NO</b></p> <p>Do You Have Blood In Urine Now _____ <b>YES</b> <b>NO</b></p> <p>Frequent Urinary Tract Infection _____ <b>YES</b> <b>NO</b></p> <p><b>ENDOCRINE:</b></p> <p>Gout _____ <b>YES</b> <b>NO</b></p> <p>Overactive Thyroid _____ <b>YES</b> <b>NO</b></p> <p>Underactive Thyroid _____ <b>YES</b> <b>NO</b></p> <p>Diabetes _____ <b>YES</b> <b>NO</b></p> <p><b>INTEGUMENTARY (SKIN DISORDERS)/AUTO IMMUNE:</b></p> <p>Rashes, Eczema, Psoriasis _____ <b>CIRCLE ONE</b></p> <p>Lupus, Scleroderma, Sjogrens _____ <b>CIRCLE ONE</b></p> <p>Melanoma _____ <b>YES</b> <b>NO</b></p> <p><b>MUSCULOSKELTAL:</b></p> <p>Osteoporosis _____ <b>YES</b> <b>NO</b></p> <p>Rheumatoid Arthritis, Inflammatory Arthritis _____ <b>YES</b> <b>NO</b></p> <p>Osteoarthritis _____ <b>YES</b> <b>NO</b></p>	<p><b>GASTROINTESTINAL:</b></p> <p>Stomach Ulcer _____ <b>YES</b> <b>NO</b></p> <p>Vomiting Blood _____ <b>YES</b> <b>NO</b></p> <p>Hiatus Hernia _____ <b>YES</b> <b>NO</b></p> <p>Heartburn or Indigestion _____ <b>YES</b> <b>NO</b></p> <p>Gallbladder Disease _____ <b>YES</b> <b>NO</b></p> <p>Liver Trouble _____ <b>YES</b> <b>NO</b></p> <p>Black Stools _____ <b>YES</b> <b>NO</b></p> <p>Recent Change In Bowel Habits _____ <b>YES</b> <b>NO</b></p> <p>Bleeding with Bowel Movements _____ <b>YES</b> <b>NO</b></p> <p>Hemorrhoids _____ <b>YES</b> <b>NO</b></p> <p>Frequent Diarrhea _____ <b>YES</b> <b>NO</b></p> <p>Abdominal Pain _____ <b>YES</b> <b>NO</b></p> <p>Weight Change Past 6 Months _____ <b>YES</b> <b>NO</b></p> <p>What change? _____</p> <p><b>HEAD-EARS-EYES-NOSE-THROAT:</b></p> <p>Chronic Sinus Trouble _____ <b>YES</b> <b>NO</b></p> <p>Impaired Hearing _____ <b>YES</b> <b>NO</b></p> <p>Dizziness _____ <b>YES</b> <b>NO</b></p> <p>Temporary Spells of Blindness _____ <b>YES</b> <b>NO</b></p> <p>Double Vision _____ <b>YES</b> <b>NO</b></p> <p>Glaucoma _____ <b>YES</b> <b>NO</b></p> <p>Cataracts _____ <b>YES</b> <b>NO</b></p> <p><b>RESPIRATORY:</b></p> <p>Spitting Up Blood _____ <b>YES</b> <b>NO</b></p> <p>Chronic or Frequent Cough _____ <b>YES</b> <b>NO</b></p> <p>Emphysema _____ <b>YES</b> <b>NO</b></p> <p>Pneumonia _____ <b>YES</b> <b>NO</b></p> <p>Recent Upper Respiratory Infection _____ <b>YES</b> <b>NO</b></p> <p>Recent Flu Symptoms _____ <b>YES</b> <b>NO</b></p> <p>Asthma _____ <b>YES</b> <b>NO</b></p> <p><b>BLOOD PROBLEMS AND BLEEDING:</b></p> <p>Do You Heal Cuts Slowly _____ <b>YES</b> <b>NO</b></p> <p>Anemia _____ <b>YES</b> <b>NO</b></p> <p>Blood Disorder _____ <b>YES</b> <b>NO</b></p> <p>Excessive Bleeding in Surgery _____ <b>YES</b> <b>NO</b></p> <p>Abnormal Bruising or Bleeding Due to Blood Thinner Meds _____ <b>YES</b> <b>NO</b></p> <p>Phlebitis or Blood Clots in Veins _____ <b>YES</b> <b>NO</b></p> <p><b>PSYCHIATRIC:</b></p> <p>Anxiety _____ <b>YES</b> <b>NO</b></p> <p>Depression _____ <b>YES</b> <b>NO</b></p> <p>Suicidal Ideation _____ <b>YES</b> <b>NO</b></p>
<b>PATIENT SIGNATURE:</b> _____	<b>DATED:</b> _____