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Name _____ Age _____ Date_____

I was referred by _____

My other doctors names are _____

The problem I am here for today is _____

_____

_____

_____

_____

_____

_____

Previous Procedures and Surgery (fill in the age at the time of the procedure)

Procedure	Age	Other Procedures	Age
☐ Cardiac catheterization			
☐ Stress Test			
☐ Echocardiogram			
☐ Pacemaker or defibrillator			
☐ Carotid artery stent or surgery			
☐ Appendectomy			
☐ Gall Bladder			
☐ Prostate surgery			
☐ Hysterectomy			
☐ Cataract surgery			
☐ Back surgery			

Previous Medical Problems (fill in the age at the time of the condition)

Medical Problems	Age	Other Medical Problems	Age
☐ Heart attack			
☐ High blood pressure			
☐ Stroke or TIA			
☐ Cancer of_____			
☐ Diabetes			
☐ Emphysema			
☐ High Cholesterol			

Write down the prescription & non-prescription drugs you are taking (pills, patches, drops)

Drug name	Dose (mg)	# of times/day	Drug name	Dose (mg)	# of times/day

Write down medicines that you have had allergies from

	☐ Rash	☐ Stomach upset	☐ Shock	☐ Other	
	☐ Rash	☐ Stomach upset	☐ Shock	☐ Other	
	☐ Rash	☐ Stomach upset	☐ Shock	☐ Other	
	☐ Rash	☐ Stomach upset	☐ Shock	☐ Other	

Your Family Medical History

	Status		Age	Significant Medical Conditions
Father	☐ Alive	☐ Deceased	.....	.....
Mother	☐ Alive	☐ Deceased	.....	.....
Brother	☐ Alive	☐ Deceased	.....	.....
Brother	☐ Alive	☐ Deceased	.....	.....
Brother	☐ Alive	☐ Deceased	.....	.....
Sister	☐ Alive	☐ Deceased	.....	.....
Sister	☐ Alive	☐ Deceased	.....	.....
Sister	☐ Alive	☐ Deceased	.....	.....

Your Personal History

My occupation is/was (circle one) _____

I live with _____

I have _____ children ranging in age from _____ to _____ years old.

☐ I've never smoked

I quit smoking _____ years/months/days ago (circle one).

I've smoked _____ packs of cigarettes per day for _____ years (fill in).

I drink _____ bottles/cans (circle one) of beer per day/week/weekends (circle one).

_____ glasses/bottles (circle one) of wine per day/week/weekends (circle one).

_____ ounces/fifths (circle one) of liquor per day/week/weekends (circle one).

I exercise ☐ Regularly and strenuously ☐ Regularly and moderately ☐ Intermittently ☐ Not at all ☐ Need help with daily activities ☐ Can't get up without help

Add anything else you want to tell the doctor

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REVIEW OF SYMPTOMS

	YES
CARDIOVASCULAR	
Are you short of breath unless you sleep on two or more pillows?	❑
Do you wake up from sleep and sit up because you are short of breath?	❑
Do you have swollen ankles or legs?	❑
Do you have chest discomfort?	❑
Do you have to stop walking because your legs cramp up? How many blocks?	❑
Have you blacked out or felt very faint for a moment?	❑
Do you feel your heart racing or palpitating?	❑
GENERAL SYMPTOMS	
Have you recently had shaking chills, intense night sweat, or fever?	❑
Have you gained weight recently? How many pounds?	❑
Have you lost weight recently? How many pounds?	❑
ENDOCRINE	
Are you very intolerant to hot weather?	❑
Are you very intolerant to cold weather?	❑
Are you drinking excesssive amounts of water and urinating very large amounts?	❑
RESPIRATORY	
Are you coughing a lot?	❑
Are you wheezing when you breathe?	❑
Have you been coughing up red blood?	❑
Do you snore loudly?	❑
Do you gasp and wake yourself while sleeping?	❑
Do you inappropriately fall asleep while riding in a car or watching a movie?	❑
GASTROINTESTINAL	
Does food get stuck when you swallow?	❑
Do you have unusual abdominal pain?	❑
Do you have frequent heartburn?	❑
Do you have coal black stool or red blood in your stool?	❑
Do you have frequent loose stools?	❑
Are you very constipated, using laxatives?	❑
HEMATOLOGY	
Do your bruise or bleed excessively?	❑
GENITOURINARY	
Have you seen blood in your urine?	❑
Do you wake up to urinate two or more times each night?	❑
MUSCULOSKELETAL	
Do you have unusual muscle pain unrelated to exercise?	❑
Do you have unusual joint aches unrelated to exercise?	❑
Do your joints become swollen and/or red? Which joints?	❑
SKIN	
Is your skin abnormally dry?	❑
Is your hair rapidly falling out?	❑
Do you have a new rash or skin lesion?	❑
NEUROLOGIC	
Have you been having unusual, prolonged or frequent new headaches?	❑
Do you have double vision so that images don't register?	❑
Have you had transient loss of vision in one eye or one side of your visual field?	❑
Have you had an episode of sudden weakness of an arm or leg on one side?	❑
Have you had an epsiode of being unable to speak normally?	❑
Have you had episodes of spinning dizziness or imbalance?	❑
PSYCHIATRIC	
Have you been very depressed, uninterested in eating, sleeping poorly, etc?	❑
Are you unusually anxious, interfering with daily life?	❑