Appointment Date: _____

Name: _____ DOB: _____Age: _____
Referring Doctor: _____Phone: _____
Primary Care Doctor: _____ Phone: _____

What is your **chief complaint/problem (**reason for your visit**)**? _____
_____

Medications (Include dose & frequency)
(1) _____ (5) _____ Do you take insulin/steroids?
(2) _____ (6) _____ **Yes** or **No**
(3) _____ (7) _____
(4) _____ (8) _____

Pharmacy: _____ Pharmacy Phone_____

Allergies to Medications (Include the type of reaction)
(1) _____ (3) _____
(2) _____ (4) _____

What are your **medical problems** (e.g., high blood pressure, diabetes, heart disease, etc.)?
(1) _____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

What **surgeries** have you had in the past? What year were they done?
(1) _____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

Family History
Father: Alive (yes or no)? Age: _____
Medical Problems: _____
Mother: Alive (yes or no)? Age: _____
Medical Problems: _____
Siblings: How many? _____ Medical Problems: _____
Children: How many? _____ Medical Problems: _____
Is there any history of cancer in your family? _____
What types and who? _____

Social History
Do you smoke (yes or no)? How much (packs / day)? _____
How many years have you or did you smoke? _____ When did you quit? _____
Do you drink alcohol (yes or no)? How much? _____
Do you drink more than two drinks daily (yes or no)?
What is your occupation? _____

When was your last: Mammogram _____Colonoscopy _____Physical _____
Did you have? Blood Work EKG Chest X-ray

Appointment Date: _____

Patient Name_____ Date of Birth: _____

Height_____ Weight_____		
Have you gained or unintentionally lost weight?(Please circle gain or loss) If 'yes' How much weight **gain/loss**? Over what time period?	YES	NO
Do you ever have fever or chills or night sweats?	YES	NO
Do you have a normal appetite?	YES	NO
Do you have nausea or vomiting?	YES	NO
Do you have diarrhea?	YES	NO
Do you have constipation?	YES	NO
Have you had a change in your bowel habits?	YES	NO
Do you ever notice blood in your stool?	YES	NO
Do you have heartburn or reflux symptoms?	YES	NO
Do you have any difficulty swallowing?	YES	NO
Do you have any hoarseness or change in your voice?	YES	NO
Do you ever have shortness of breath when resting or sleeping?	YES	NO
Have you ever had pneumonia? When? _____	YES	NO
Do you have sleep apnea?	YES	NO
Do you have a persistent cough?	YES	NO
Do you ever have chest pain, at rest or exertion?	YES	NO
Have you had a heart attack, especially in the last six months?	YES	NO
Have you ever had a "stress test"? When? _____Where? _____	YES	NO
Have you ever had a "heart cath"? When? _____ Where? _____	YES	NO
Have you ever had heart angioplasty, stents or heart surgery? (circle) When? _____	YES	NO
Do you ever have irregular heartbeats?	YES	NO
Have you ever been hospitalized with congestive heart failure? When? _____	YES	NO
Do you have swelling of your legs?	YES	NO
Have you ever had a blood clot in your legs or lungs?	YES	NO
Have you ever had surgery to improve blood flow in your legs?	YES	NO
Do you have any difficulty urinating?	YES	NO
Are you on dialysis? What type? _____ What days do you have dialysis? _____	YES	NO
Do you have any family or personal history of easy bruising? Who? _____	YES	NO
Have you or a family member ever had difficulty with anesthesia? Who and what type of reaction? _____	YES	NO
Do you have any history of stroke? If yes, do you still have any persistent weakness or deficit?	YES YES	NO NO
Do you perform routine self breast examinations?	YES	NO
Do you have nipple discharge?	YES	NO
Have you received chemotherapy or radiation in the last 30 days?	YES	NO
Have you had any surgery in the last 30 days?	YES	NO
Do you have any open wounds?	YES	NO
Do you have anxiety or depression?	YES	NO
Do you live independently?	YES	NO

Appointment Date: _____

2/12/16