



In: _____

Out: _____

Date: _____

Name:

First _____ Middle _____ Last _____

Preferred name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Cell: _____

Birthdate: _____ Social Security # _____

Work address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Emergency Contact Person Name: _____ Phone#: _____

Preferred Pharmacy: _____

Pharmacy Address: _____ Phone#: _____

Referring Physician: _____ Phone #: _____

Primary Physician: _____ Phone#: _____

ALLERGIES:

Insurance: _____

Primary Insured Name: _____

Birthdate: _____ SS#: _____

Relationship to patient: _____



Name: _____ Date: _____

Describe the present problem that brings you to this office. Please be specific with symptoms.

Family History: (check/answer all that apply)

	Heart disease	High blood pressure	Diabetes	High cholesterol	Stroke	Peripheral vascular disease
Father	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Mother	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Brother(s)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Sister(s)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Self	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Review of systems: (Please check all that apply)

Yes	No	<u>Constitutional</u>	Yes	No	<u>Musculoskeletal</u>
Yes	No	Trouble sleeping	Yes	No	Difficulty walking
Yes	No	Lack of energy	Yes	No	Joint pain/swelling
Yes	No	Appetite changes	Yes	No	Back Pain
Yes	No	Thyroid problems			<u>Skin</u>
Yes	No	Fevers/frequent infections	Yes	No	Non-healing sores
		<u>HEENT</u>			<u>Gastrointestinal</u>
Yes	No	Serious eye problems			Liver problems
Yes	No	Hearing problems	Yes	No	Nausea/vomiting
Yes	No	Nose problems	Yes	No	Heartburn
Yes	No	Throat problems	Yes	No	Constipation
		<u>Cardiac</u>	Yes	No	Blood in stool
Yes	No	Chest pain	Yes	No	Diarrhea
Yes	No	Heart rhythm problems	Yes	No	Swallowing difficulties
Yes	No	Fainting or blackouts	Yes	No	Abdominal pain
Yes	No	Heart Murmur			<u>Neurological</u>
Yes	No	Swelling			Numbness/Tingling
Yes	No	Leg/buttock pain	Yes	No	Dizziness
		<u>Respiratory</u>	Yes	No	Weakness
Yes	No	Shortness of breath	Yes	No	Seizures
Yes	No	Cough/sputum/phlegm			<u>Genito-Urinary</u>
Yes	No	Wheezing			Recurrent urinary tract infection
Yes	No	Chronic lung disease	Yes	No	Frequent urination at night
		<u>Hematological</u>	Yes	No	Difficult urination
Yes	No	Bleeding disorders	Yes	No	Prostate problems
Yes	No	Anemia	Yes	No	Kidney stones
Yes	No	Blood clots	Yes	No	Pregnancy
			Yes	No	Loss of bladder control
			Yes	No	Kidney Problems

Past Medical History: _____