NAME: ____________________________ **AGE:** _______ **HEIGHT:** ______ **WEIGHT:** _______ **DATE:** ___________

REASON FOR THIS VISIT: ____

PAST MEDICAL HISTORY: (**circle** the conditions you have) **NONE**

Arthritis	Emphysema/COPD	High Cholesterol	Brain Hemorrhage (bleed)
Chronic Back/Joint Problems	Diabetes	Congestive Heart Failure	Heart Attack
Headaches/Migraines	Blood Clots	High Blood Pressure	Atrial Fibrillation
Head Injury	Skin Conditions	Kidney Disease	Angina
Depression	Cancer	Ulcers	Miscarriage
Glaucoma/Cataracts	Seizures	Hepatitis/Liver Disease	Bleeding Ulcer
Thyroid Disease	Stroke	Inflammatory Bowel Disease	Kidney Stone
Asthma	Heart Disease	HIV/AIDS	Bipolar
			Anxiety

Other: ____

PAST SURGICAL HISTORY: (**circle** the operations you have undergone) **NONE**

Heart Valve Repl.	Stomach Surgery	Gallbladder Removal	Fracture Repair	Stent
Heart Bypass Surgery	Tonsillectomy	Brain Surgery	Glaucoma Surgery	Aortic Aneurysm Repair
Appendectomy	Colon Surgery	Back Surgery	Cataract Surgery	Hip Replacement
Splenectomy	Hernia Repair	Bone/Joint Surgery	Aortofemoral Bypass	Knee Replacement
			Carotid Endarterectomy	Pacemaker/Defibrillator

ALLERGIES: NONE YES: ____

REVIEW OF SYSTEMS: (**circle** the symptoms you have experienced in the **past 12 months**) **NONE**
All symptoms not circled will be considered negative

Fever	Chest pain	Headache	Sad/depressed	Frequent infections
Night sweats	Short of breath	Unsteadiness	Trouble sleeping	Allergies
Visual loss	Passing out	Dizziness	Under a lot of stress	Skin rash
Double vision	Belly pain	Speech difficulty	Confusion	Easy bruising
Hearing loss	Nausea/vomiting	Numbness	Weight gain or loss	Incontinence
Swallowing trouble	Neck or back pain	Weakness	Fatigue	Sexual dysfunction

SOCIAL HISTORY: (**circle** answers and **fill in the blanks**)

Do you drink coffee/tea/cola drinks? **Y N** What? _____________________________ How much? _____________________
Do you use tobacco? **Y N** How much? _____________________________When did you quit? ________
Do you drink alcohol? **Y N** What and how much? ______________________When did you quit?________
Do you use recreational/street drugs? **Y N** What kind? ______________________________ When did you quit? _______

Currently employed? **Y N RETIRED** **TYPE OF JOB**: ____

Marital status: **SINGLE MARRIED PARTNERED WIDOWED SEPARATED DIVORCED**
Do you have children? **Y N** How many? ___
Living arrangement: ____
Highest level of education: ______________________________ Do you exercise? **Y N** Type___________How often_______

FAMILY HISTORY: (**circle condition** and **specify the family member** who has it) **NONE**

Heart Problem	Alcohol/Drug Addiction	Neuropathy	Multiple Sclerosis
Stroke	Family Deceased	High Cholesterol	ALS/Motor Neuron Disease
Diabetes	Cancer	Brain Aneurysm	Epilepsy/Seizures
High blood pressure	Blood Clots	Muscular Dystrophy	Migraines
Mental Illness	Kidney Disease	Alzheimers/Dementia	Myasthenia Gravis
		Parkinsons/Tremor	