Name:_____ **DOB:**_____

Referring Provider: _____

<u>Past Medical History</u>: (Please place a check mark by any condition that you have now or had in the past)

Cardiac/Vascular

- ☐ Aneurysm
- ☐ Angina/Chest Pain
- ☐ Arrhythmia (heart rhythm)
- ☐ Atrial Fibrillation
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ TIA (mini or temporary stroke)

Gastrointestinal

- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ Stomach Ulcer

Hematologic/Oncologic

- ☐ Bleeding Disorder
- ☐ Cancer

Type:_____

- ☐ Heart Murmur
- ☐ Heart Valve Disease

Rheumatologic

- ☐ Autoimmune Disease
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Rheumatism Arthritis

Endocrine

- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Graves Disease

Infectious

- ☐ HIV/AIDS
- ☐ Rheumatic Fever
- ☐ Syphilis

Respiratory

- ☐ Asthma
- ☐ Chronic bronchitis
- ☐ Emphysema/ COPD
- ☐ History of Tobacco Use

Neurologic/Psychiatric

- ☐ Alzheimer's Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Parkinson's Disease
- ☐ Seizure Disorder

GU/Misc.

- ☐ Breast Disease
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Prostate Disease

Other:_____

Surgical History: (please place a check mark by any previous surgery and indicate the approximate date of surgery)

- ☐ Never had any surgery
- ☐ Aneurysm Repair _____
- ☐ Angioplasty/ PTCA _____
- ☐ Appendectomy _____
- ☐ Carotid Artery Bypass _____
- ☐ Cataract Removal _____
- ☐ Cesarian Section _____
- ☐ Coronary Artery Bypass _____
- ☐ Coronary Stent _____
- ☐ Gallbladder _____
- ☐ Hernia Repair _____
- ☐ Hysterectomy _____
- ☐ Orthopedic (type:_____)
- ☐ Splenectomy _____
- ☐ Tonsillectomy _____
- ☐ Tubal Ligation (Female) _____
- ☐ Vascular Surgery _____
- ☐ Vasectomy _____
- ☐ Other _____

Does anyone in your family have a history of heart problems? _____

Social History

Pharmacy:_____

Do you have Home Health? Yes or No

Do you drink any caffeinated drinks? Yes or No Type:_____ How Many:_____

Tobacco and Alcohol History

Do you smoke? Yes Or No

If No: Did you ever smoke? Yes or No

How many years did you smoke? _____

What year did you quit? _____

Do you drink alcohol? Yes or No

Average a week? _____

Review of Symptoms

Check the boxes below if you have any of the following symptoms for today:

Respiratory

- ☐ Shortness of breath
- ☐ Congestion
- ☐ Cough short of breath on exertion

Cardiology

- ☐ Chest pain
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Sweating
- ☐ Swelling
- ☐ Fluttering sensation

General

- ☐ Weight gain
- ☐ Weight loss
- ☐ Loss of appetite
- ☐ Fevers
- ☐ Weakness
- ☐ fatigue

Endocrine

- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Increased thirst

Female Reproductive

- ☐ Pregnant
- ☐ Menopause

Ophthalmology

- ☐ Diminished Vision
- ☐ Blurring of vision
- ☐ Loss of vision
- ☐ Vision floaters

Urology

- ☐ Frequent urination
- ☐ Difficult or painful urination
- ☐ Blood in urine

Neurology

- ☐ Headaches
- ☐ Tingling
- ☐ Fainting
- ☐ Dizziness
- ☐ Difficulty walking
- ☐ Memory loss

Gastroenterology

- ☐ Nausea
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Abdominal pain

Hematology

- ☐ Easy bruising
- ☐ Bleeding

Psychology

- ☐ Depression
- ☐ Anxiety
- ☐ High Stress

Male Reproductive

- ☐ Difficulty with erection

Musculoskeletal

- ☐ Joint pain
- ☐ Leg cramps
- ☐ Back pain
- ☐ Arm pain
- ☐ Neck pain
- ☐ Leg pain
- ☐ Muscle pain skin

Dermatology

- ☐ Rash
- ☐ Flushing
- ☐ Wound
- ☐ Dry