

Name:	DOB:/	/Today	y's Date:/	/
Cell or Home Phone Number: ()	_ Email:			
What is the main reason for your visit? (i.e., checku	up)			
Were you referred by another doctor? Yes	No If yes, wh	10?		
Do you have a primary care doctor? Who?				None
Who, if any, are the specialists you see?				
	an Referral Fi			
	•			
	•			
RECENT SYMPTOMS  1. Do you have chest pain?			Yes	No
2. Do you have shortness of breath?		-	Yes	— No
a. If yes, with exertion?		-	Yes	No No
b. If yes, while lying flat in bed?		-	Yes	No
c. If yes, does it wake you at night?		_	Yes	No
3. Have you had swelling in your legs?			Yes	No
4. Do you routinely develop pain in your leg	s when you walk?		Yes	No
5. Have you passed out recently?		-	Yes	<u>No</u>
6. Have you felt your heart beating fast or s	kipping for no rea	ason?	Yes	No
High Blood Pressure  High Cholesterol  Diabetes  Heart Attack		0 0 0	<u>ed</u>	
PAST SURGICAL HISTORY		** **		
Type of Surgery 1.		Year of Surge	<u>ry</u>	
7. 2. 3. FAMILY MEDICAL HISTORY Do heart attacks run in your family? If yes, who, and at what age did they have  Please list any health concerns (especially (click to select option) Father: (Alive or Deceased?) Mother: (Alive or Deceased?) Paternal Grandparents: (Alive or Decease	Yes No e it?			
Maternal Grandparents: (Alive or Decease	sed?)			
Siblings: (Alive or Deceased?)				

SOCIAL HISTORY				
1. Do you currently smo	oke? Yes	No Never	Number of pack	s per day:
• If no, how long	ago did you qu	uit?		
2. Do you exercise routi	nelv? Yes	No Type:		
3. Do you currently drin	ık caffeine?	Yes	No Number	r of drinks per day:
3. Do you currently drin 4. Do you currently drin	ik alcohol?	Ves _	No Number	r of drinks per day:
5 Occupation:	in diconor.			or urming per uny.
5. Occupation: Re	atinad	Unamplayed	Disabl	od.
				eu
Please list your <u>current medica</u>	<u>ttions</u> below (or	type 'none' if appropr		Emagnanay
<u>me</u>			<u>Dose</u>	<u>Frequency</u>
Please list any <u>medication aller</u>	gies below (or t	ype 'none' if appropria	ite):	
What Pharmacy do you use? P	lease provide a	ddress and phon	e number if know	n:
REVIEW OF RECENT SYST	EMS: (click yes o	r no)		
Constitutional:				
Fevers		Yes	No	
	<del>-</del>	+~	· -	
<b>Endocrine:</b>				
Fatigue	_	Yes	_ No	
Gastrointestinal:		<b>V</b> /22	No	
Abdominal Pain	_	Yes	-No	
Black (tar colored) stool	_	Yes	_ No	
Musculoskeletal:				
<b>Muscle Aches</b>	_	Yes	_ No	
Neurology:				
Weakness in the arms or legs				
			No	
visuai Changes	_	Yes	_ No No	
Visual Changes	- -		_ No _ No	
Psychiatric:	- -	YesYes	No	
G	- -	Yes		
Psychiatric: Depression	- - -	YesYes	No	
Psychiatric:	- -	YesYes	No	