



New Patient History

Name: _____ Date: _____

Referring Physician: _____

Reason for visit: _____

Past Medical History

Heart	angina pacemaker irregular heart other _____	high blood pressure AICD blood clots	heart attack date: _____ valve problems congestive heart failure
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Lungs	asthma other _____	COPD	emphysema
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Neuro/ Vascular	stroke head injury other _____	vertigo weakness/tremors	seizures numb: hands/feet/legs
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Endocrine	Diabetes Insulin other _____	low thyroid	high thyroid
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GI	ulcers colitis diarrhea other _____	reflux liver disease constipation	hiatal hernia gallbladder disease
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GU/GYN	prostrate problems other _____	last menstrual cycle _____
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Blood	bleeding disorder other _____	HIV positive	anemia
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ENT	visual problems other _____	hearing problems
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Surgical History

Please list any past surgeries/major procedures or hospitalizations:

Date	Surgery/Illness

Family History

Has anyone in you family ever had any of the following illnesses or diseases?

Yes	No	Relative	Illness/Disease
			High Blood Pressure
			Congestive Heart Failure
			Sudden unexplained death
			Diabetes
			Heart Attack at what age:
			Stroke

Social History

Are you currently employed? yes employed as: _____

no retired from _____

Are you: Single Married Widowed Divorced

Do you have children? # _____

Do you smoke? Yes No
 Packs a day _____ for # _____ years

Do you drink alcohol? socially daily weekly never

Review of Systems

Please check *yes* or *no* if you have had any of these symptoms in the *last 6 months*:

Yes	No	Symptom or problem
		Unexplained weight loss/gain
		Profound fatigue
		Unexplained fever

		Numb face, arms or legs
		Loss of vision in one eye
		Blurred vision
		Dizziness
		Difficulty with your memory

		Eye infection
		Infection in your mouth
		Enlarged thyroid

		Shortness of breath
		Productive cough
		Sleeping with two or more pillows at night
		Sleeping in a chair at night
		Prolonged respiratory infection

		Chest pain/heaviness
		Angina during sleep
		Irregular heart beat
		Racing heart
		Blackout or fainting

		Pain in your legs after walking a short distance
		Swelling in your legs

		Change in you bowel function
		Blood in you urine or stool
		Nausea

		Do you have diabetes?
		Are you Insulin dependent?
		Are your blood sugars well controlled?
		Do you wake up with a sweat in the middle of the night?
		Do you have heat cold intolerance?

Is there anything else you would like us to know about your health?