**Medication List:**

|  |  |  |
| --- | --- | --- |
| Drug Name |  | Dosage |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**PAST MEDICAL HISTORY** Check below if you have any of the following:

☐ Coronary Artery Disease ☐ Myocardial Infarction ☐ Congestive Heart Failure ☐ Atrial Flutter ☐ Atrial Fibrillation

☐ Other Arrhythmia ☐ Heart Valvular Disorder ☐ Peripheral Vascular Disease ☐ Carotid Artery Disease

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Stroke ☐ COPD/Asthma

☐ Kidney Disease ☐ Tobacco Use ☐ Blood Disorder ☐ Venous Insufficiency

☐ Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies:**

|  |  |
| --- | --- |
| Drug Name | Type of Reaction |
|  |  |
|  |  |
|  |  |
|  |  |

Are you allergic to Latex? ☐ Yes ☐ No

List any **SURGERY(S)/HOSPITALIZATIONS** you have had:

|  |  |  |
| --- | --- | --- |
| Type | Date | Outcome |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**FAMILY HISTORY** Describe current health, age, cause of death, and illness of family members

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Age | Alive | Deceased | Cause of Death | Medical History |
| Father |  |  |  |  | ☐ Heart Attack ☐ Coronary Artery Disease ☐ Heart Disease ☐ Hypertension  ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Mental Illness |
| Mother |  |  |  |  | ☐ Heart Attack ☐ Coronary Artery Disease ☐ Heart Disease ☐ Hypertension  ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Mental Illness |
| Sibling 1  Brother  Sister |  |  |  |  | ☐ Heart Attack ☐ Coronary Artery Disease ☐ Heart Disease ☐ Hypertension  ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Mental Illness |
| Son |  |  |  |  | ☐ Heart Attack ☐ Coronary Artery Disease ☐ Heart Disease ☐ Hypertension  ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Mental Illness |
| Daughter |  |  |  |  | ☐ Heart Attack ☐ Coronary Artery Disease ☐ Heart Disease ☐ Hypertension  ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Mental Illness |

**SOCIAL HISTORY/HABITS**

**TOBACCO USE**

Do you currently use Tobacco products? ☐ Yes ☐ No

Starting Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Years Smoked \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year Stopped \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate the quantity per day:

Cigarettes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cigars \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chewing Tobacco \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXERCISE**

Do you currently exercise? ☐ Yes ☐ No

Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Activity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALCOHOL/DRUG USE**

Do you currently consume alcoholic beverages? ☐ Yes ☐ No

If yes, indicate the quantities consumed per day: Beer \_\_\_\_\_\_\_\_\_ Wine \_\_\_\_\_\_\_\_ Distilled spirits \_\_\_\_\_\_\_\_

Have you used drugs other than those for medical reasons in the past 12 months? ☐ Yes ☐ No

Have you ever been treated for drug or alcohol addiction? ☐ Yes ☐ No

**CAFFIENE USE**

Do you currently use Caffeine products? ☐ Yes ☐ No

Type of Product \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Indicate the quantity per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of System:** Please check all that apply currently affecting you today.

**General/Constitutional:**

☐ Chills ☐ Fever ☐ Night Sweats ☐ Weight Gain ☐ Weight Loss

**Ophthalmologic:**

☐ Discharge ☐ Red eye

**Ear, Nose, Throat:**

☐ Decreased Hearing ☐ Sore Throat ☐ Swollen Glands

**Endocrine:**

☐ Fatigue ☐ Cold Intolerance ☐ Excessive Thirst ☐ Heat Intolerance ☐ Weight Loss

**Respiratory:**

☐ Cough ☐ Shortness of Breath ☐ Sputum Production ☐ Wheezing

**Cardiovascular:**

☐ Cold Sweats ☐ Chest Pressure ☐ Chest Pain at rest ☐ Chest Pain on Exertion ☐ Leg Swelling

* Irregular Heart Beats ☐ Palpitation ☐ Fainting

**Gastrointestinal:**

☐ Abdominal Pain ☐ Bloody Stool ☐ Diarrhea ☐ Difficulty Swallowing ☐ Heart Burn

☐ Vomiting Blood ☐ Nausea ☐ Vomiting

**Genitourinary:**

☐ Blood in Urine ☐ Difficulty Urinating ☐ Frequent Urination ☐ Pain with Urination

**Musculoskeletal:**

☐ Leg cramps ☐ Painful Joints ☐ Weakness

**Peripheral Vascular:**

☐ Varicose Veins ☐ Cold Extremities ☐ Pain/cramping in legs after exertion ☐ Ulceration of feet

**Skin:**

☐ Discoloration ☐ Dry skin ☐ Itching ☐ Rash ☐ Scars

**Neurological:**

☐ Balance Difficulty ☐ Dizziness ☐ Headaches ☐ Focal Weakness ☐ Memory loss ☐ Numbness / Tingling

☐ Tremors

**Psychiatric:**

☐ Anxiety ☐ Depressed mood **Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**