|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last name: | First Name: | Middle: | Birth Date: | Age: |

|  |
| --- |
| Primary care physician (PCP) |
| Please list other physicians: |
| Local Pharmacy:  Prefer 30 day or 90 day supply? |
| If used, mail order pharmacy: |

Please list ***changes*** to family history by listing family member relationship and medical problem, i.e. heart attack, stroke, hypertension, heart disease, heart failure, etc.

|  |
| --- |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Tobacco | □ Never | □ Former | □ Current | □ Cigarettes / Amount □ Pipe □ Cigar |
| Smokeless Tobacco | □ Never | □ Former | □ Current | □ Snuff □ Chew |
| Alcohol | □ Never | □ Daily | □ Socially | How much weekly? |
| Exercise | □ None | □ Yes | How often? | What type? |

**Since your last office visit have you:**

|  |  |
| --- | --- |
| Been hospitalized? |  |
| Had procedures/tests? |  |
| Had medication changes? |  |

Are you planning surgery within the next six months? □ No If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check below any NEW or CHANGED symptoms SINCE YOUR LAST OFFICE VISIT.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Constitution**: | **Eyes** | **Gastroenterology** | **Endo/Heme/Allergy** |
| □ Fever  □Chills  □ Weight loss  □ Malaise/fatigue  □ Diaphoresis  □ Weakness  □ Snoring | □ Blurred vision  □ Double vision  □ Photophobia  □ Eye pain | □ Heartburn  □ Nausea  □ Vomiting  □ Abdominal pain  □ Diarrhea  □ Constipation  □ Blood in stool  □ Melena (dark stool) | □ Bruise easily/bleed  □ Polydipsia (excessive thirst) |
| **Neurological** |
| □ Dizziness  □ Headaches  □ Speech change  □ Focal weakness  □ Seizures  □ Loss of consciousness |
| **Skin** | **Cardiovascular** | **Urinary** | **Psychiatric** |
| □ Rash  □ Itching | □ Chest pain  □ Palpitations  □ orthopnea (unable to lie flat)  □ Claudication (pain w/walking)  □ Leg swelling  □ PND (shortness of breath at night) | □ Difficulty urinating  □ Urgency  □ Frequent urination  □ Blood in urine  □ Flank pain | □ Depression  □ Suicidal ideas  □ Substance abuse  □ Hallucinations  □ Nervous/anxious  □ Insomnia  □ Memory loss |
| **HENT** |
| □ Hearing loss  □ Tinnitus  □ Ear pain  □ Nosebleeds  □ Congestion  □ Sinus pain  □ Sore throat |
| **Respiratory** | **Musculoskeletal** |
| □ Cough  □ Hemoptysis (blood in sputum)  □ Sputum production  □ Shortness of breath  □ Wheezing | □ Muscle pain  □ Neck pain  □ Back pain  □ Joint pain  □ Falls |

**Do you have painful varicose veins?** □ Yes □ No