|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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