Appointment Date: _____

Name:_____ **Date of Birth:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

Is it ok to leave a detailed message ☐ **Yes** ☐ **No**

Preferred Email Address: _____

Emergency Contact Name: _____

Phone Number: _____

Relationship:_____

PHARMACY INFORMATION

1. _____CITY:_____NUMBER:_____

2. _____CITY:_____NUMBER:_____

Physician's name (s) who should receive medical information from us:

1._____

2._____

3._____

4._____

5._____

MEDICATION ALLERGIES AND THEIR REACTION

- **Please list any ALLERGIES to medications or foods:**
  _____
  _____
  _____
- **ARE YOU ALLERGIC TO LATEX?** NO / YES
- **ARE YOU ALLERGIC TO IODINE/ IV CONTRAST/ XRAY DYE?** NO / YES

CURRENT MEDICATIONS

(IF YOU HAVE A LIST PLEASE PROVIDE AND WE WILL PHOTOCOPY IT)

Name of medicine, vitamin, or supplement	Dosage	Frequency	What is the reason you take this?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			

ARE TAKING ANY OF THE FOLLOWING BLOOD THINNING MEDICATION?

Aspirin ? NO YES
Plavix ? NO YES
Coumadin? NO YES

WHY ARE YOU PRESCRIBED THIS MEDICATION? _____

WHO PRESCRIBES THIS MEDICATION? _____

What is the reason for today's visit?

_____

_____

Duration of symptoms? _____

Circle if you have or have EVER had any of the following:

High Blood Pressure	Y / N	Dementia	Y / N
Diabetes	Y / N		
		Blood Clots (DVT)	Y / N
Bleeding Disorder	Y / N	HIV / AIDS	Y / N
Stroke	Y / N	Liver Failure	Y / N
Kidney Failure	Y / N		
Kidney Disease	Y / N		
Heart Attack	Y / N		
-When_____		Hepatitis	Y / N
Cardiac Stents	Y / N	Ulcer	Y / N
When/Where -_			
Atrial Fibrillation	Y / N	Cancer	Y / N
High Cholesterol	Y / N	- Type-	
Chest Pain with exertion	Y / N		
Unexplained Chest Pain at Rest	Y / N		
Congestive Heart Failure	Y / N		
Congenital Heart Defect	Y / N	Additional medical conditions not listed above:	
Atrial or Ventricular Septal Defect			
Patent Foramen Ovale	Y / N	_____	
COPD	Y / N	_____	
Lung Disease	Y / N	_____	
Peripheral Neuropathy	Y / N	_____	
	Y / N	_____	
		_____	
		_____	
		_____	

DO YOU HAVE A HISTORY OF SLEEP APNEA? NO / YES
DO YOU USE A BREATHING MACHINE (CPAP / BI-PAP) ? NO / YES

PAST SURGICAL HISTORY:

Operation: _____ Date _____

Operation: _____ Date _____

Operation: _____ Date _____

Operation: _____ Date _____

Operation: _____ Date _____

Operation: _____ Date _____

SOCIAL HISTORY

Please circle the appropriate response.

Currently employed? NO / YES - Occupation_____
Retired? NO / YES
Disability? NO / YES

Marital Status: Single / Married / Separated / Divorced / Widowed

Tobacco Use:
Never / Current Use / Prior Use
Packs per day of Cigarettes:_____
Number of Years: ____

Alcohol Use:
Never Rarely Occasionally Current Use Prior Use

Estimated Number of Drinks per Week: __

Type of Alcohol: Beer Wine Spirits

Drug Use:

Never Rarely Occasionally Current Use Prior Use

Marijuana IV drugs Cocaine Methylphenidate

FAMILY HISTORY

Please list age, health status, and cause of death (if deceased).

Father_____Mother_____
Siblings_____Children _____
____ No knowledge of family medical history.

Please circle the appropriate response.

Does anyone in your family have cancer?	NO	YES
Does anyone in your family have diabetes?	NO	YES
Does anyone in your family have high blood pressure?	NO	YES
Does anyone in your family have heart disease?	NO	YES
Does anyone in your family have kidney disease?	NO	YES
Has anyone in your family had a stroke?	NO	YES
Does anyone in your family have a bleeding/clotting disorder?	NO	YES

Please further explain any "YES" responses to the above questions: ____

Review of Systems

Please mark any active problems that exist. Provide additional details in the comments section.

System	Review	Comments
General Health	□ Unexplained weight gain or loss □ Loss of appetite □ Fatigue □Fevers/Chills □ No problems	
Skin	□ Rash □Changes in skin color □Yellowing of eyes □Non-healing wounds (Specify past /present & location of wounds) □ No problems	
Cardiovascular	□Irregular heart beat □Palpitations □Chest pain □ No problems	
Pulmonary	□Shortness of breath □ Wears oxygen □Sleep Apnea □ No problems	
Hematologic	□Abnormal Bruising □Easily bleeds □ No problems	
Gastrointestinal	□Difficulty swallowing □Abdominal pain □Nausea/vomiting □Diarrhea □Blood in stool □ No problems	
Genitourinary	□Frequent urination □Blood in urine □Prostate problems □Urinary incontinence □ No problems	
Psychological	□Depression □Anxiety □Hallucinations □No problems	
Musculoskeletal	□Back pain □ Joint pain □ Muscle cramping □Leg swelling □Leg/Foot pain at rest (Left / Right) □ Leg pain with walking (Left / Right) □ Use of: □ Cane □ Walker □ Wheelchair □ Compression stockings □ No problems	
Neurology	□Dizziness □ Limb weakness □Tingling/numbness □Frequent Falls □ No problems	
Additional Information		

******** NURSING USE ONLY****DO NOT FILL OUT BELOW THIS LINE ***********

VITAL SIGNS:

HEART RATE: _____ RR: _____ PULSE OX: _____ TEMPERATURE: _____

RIGHT ARM BLOOD PRESSURE: _____

LEFT ARM BLOOD PRESSURE: _____

HEIGHT: _____ WEIGHT: _____

PULSES/PRESSURES

Right		**Left**	
BRACHIAL		**BRACHIAL**	
DP		**DP**	
PT		**PT**	

ABI RIGHT:_____ ABI LEFT: _____

Date Collected _____

Hemoglobin		**INR Total**	
WBC		**Total Bilirubin**	
Platelets		**AST**	
Creatinine		**ALT**	