



PLEASE ANSWER ALL INFO BELOW

DATE _____ CHART # _____

Name: _____ Age: _____ DOB _____

Referred by: _____ Primary Care Dr: _____

Pharmacy: _____ Lab Used: _____

Do you have, or have you ever had any of the following? Please check all the apply.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Nausea | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fever/chills | <input type="checkbox"/> Asthma | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> Prior heart attack | <input type="checkbox"/> pneumonia | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Chest pain/Angina | <input type="checkbox"/> Emphysema | <input type="checkbox"/> ulcer | <input type="checkbox"/> Muscle aches |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Leg cramping | <input type="checkbox"/> headaches | <input type="checkbox"/> hepatitis | <input type="checkbox"/> Anemia/ Bleeding |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Gallstones UTI | <input type="checkbox"/> Cancer of _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Urination @ night | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Swelling / Edema | | <input type="checkbox"/> Heart Failure |

Pacemaker/ defib Type _____

<p>Drug allergies (Please List) *Are you allergic to IV dye, Iodine or shellfish? <input type="checkbox"/> Yes <input type="checkbox"/> NO</p>	<p>DATE SURGERY</p>
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<p>Social History: Occupation _____ <input type="checkbox"/> Retired <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Family History</p> <table border="0" style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">Father</td> <td style="text-align: center;">Mother</td> <td style="text-align: center;">Siblings</td> </tr> <tr> <td>Age</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Heart Disease</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>High Blood Pressure</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Stroke</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Cancer</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Diabetes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Father	Mother	Siblings	Age	_____	_____	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Ever Used Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No Packs Daily __ How Long __ Quit _____ Coffee Daily ____ <input type="checkbox"/> Decaf <input type="checkbox"/> Regular Alcohol Use <input type="checkbox"/> No <input type="checkbox"/> Yes How Often _____ Recreational Drugs <input type="checkbox"/> No <input type="checkbox"/> Yes Type _____ Exercise Routine <input type="checkbox"/> No <input type="checkbox"/> Yes How Often _____</p>
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Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																										

<p>Current Medications LIST ALL with DOSE</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Comments to share with doctor</p>
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