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PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

Name: ______________________________ Age: ____________

Family Doctor: ______________________________ Date: ____________

Problem: ______________________________

DO YOU HAVE ANY OF THE FOLLOWING ILLNESSES? Check YES or NO

Diabetes	❑ Yes	❑ No	Stroke	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No	Lung Disease	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Seizures	❑ Yes	❑ No	Arthritis	❑ Yes	❑ No	Bleeding Tendencies	❑ Yes	❑ No
Thyroid Disease	❑ Yes	❑ No	Cancer	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No

PLEASE LIST PREVIOUS SURGERIES - WHEN? ______________________________

____

____

Current Medications:	**Dosage (MG)**	**How Often Per Day?**

Are You Taking ASPIRIN or other blood thinners (Coumadin / Warfarin)? ❑ **Yes** ❑ **No**

Allergies: ______________________________

SOCIAL HABITS:

Use of Tobacco: Never ________ Current Packs Per Day ______ Previously, But Quit ____ When ________

Use of Alcohol: Never ________ Occasionally ________ Daily ________

FAMILY HISTORY: Does Anyone In Your Family Have The Following:

❑ Diabetes ❑ Stroke ❑ Kidney Disease ❑ Heart Disease

❑ Lung Disease ❑ High Blood Pressure ❑ Bleeding Tendencies ❑ Aneurysm

❑ Varicose Veins Type / Who: ______________________________

❑ Cancer Type / Who: ______________________________

❑ Peripheral Vas. Disease Type / Who: ______________________________

(Over)

Are You Experiencing Any Of The Following?

Constitutional

Fever ❑ Yes ❑ No
Fatigue ❑ Yes ❑ No
Recent Weight Change ❑ Yes ❑ No
Insomnia ❑ Yes ❑ No
Stress ❑ Yes ❑ No

Eyes

Wear Glasses / Contacts ❑ Yes ❑ No
Eye / Vision Problems ❑ Yes ❑ No

Ears, Nose, Mouth, Throat

Ear Aches ❑ Yes ❑ No
Hearing Loss / Ringing ❑ Yes ❑ No
Nose Bleeds ❑ Yes ❑ No
Sinus Problems ❑ Yes ❑ No
Frequent Colds ❑ Yes ❑ No
Dental Problems ❑ Yes ❑ No
Sore Throat / Hoarseness ❑ Yes ❑ No

Cardiovascular

Chest Pain ❑ Yes ❑ No
Irregular / Fast Heartbeat ❑ Yes ❑ No
Cold Extremities ❑ Yes ❑ No
Numbness / weakness - arms / legs ❑ Yes ❑ No
Varicose veins / phlebitis ❑ Yes ❑ No
Swelling of feet / ankles ❑ Yes ❑ No
Pain when walking ❑ Yes ❑ No

Respiratory

Coughs ❑ Yes ❑ No
Shortness of breath ❑ Yes ❑ No
Spitting up blood ❑ Yes ❑ No
Asthma / wheezing ❑ Yes ❑ No

Gastrointestinal

Loss of appetite ❑ Yes ❑ No
Nausea / vomiting ❑ Yes ❑ No
Diarrhea ❑ Yes ❑ No
Constipation ❑ Yes ❑ No
Change in bowels ❑ Yes ❑ No

Hematological / Lymphatic

Slow to heal after cuts ❑ Yes ❑ No
Anemia ❑ Yes ❑ No
Blood transfusions ❑ Yes ❑ No
Bleeding / bruising ❑ Yes ❑ No
Swollen Glands ❑ Yes ❑ No

Allergy / Immunologic

Allergies ❑ Yes ❑ No
Hepatitis ❑ Yes ❑ No
HIV / AIDS ❑ Yes ❑ No

Musculoskeletal

Joint pain / Swelling ❑ Yes ❑ No
Muscle joint weakness ❑ Yes ❑ No
Back Pain ❑ Yes ❑ No

Neurological

Frequent Headaches ❑ Yes ❑ No
Light Headed / Dizzy ❑ Yes ❑ No
Seizures ❑ Yes ❑ No
Paralysis ❑ Yes ❑ No
Change in Speech ❑ Yes ❑ No

Psychiatric

Memory Loss / Confusion ❑ Yes ❑ No
Nervousness / Depression ❑ Yes ❑ No

Endocrine

Hormone Problem ❑ Yes ❑ No
Excessive Thirst or Urination ❑ Yes ❑ No
Heat / Cold Intolerance ❑ Yes ❑ No

Integumentary / Breast

Rash / Itching ❑ Yes ❑ No
Change in skin / hair / nails ❑ Yes ❑ No
Yellow Jaundice ❑ Yes ❑ No
Breast Pain ❑ Yes ❑ No
Breast Lump ❑ Yes ❑ No
Nipple Discharge / Bleeding ❑ Yes ❑ No

Genitourinary

Frequent urination ❑ Yes ❑ No
Painful / burning urination ❑ Yes ❑ No
Bladder control problem ❑ Yes ❑ No
Kidney stones ❑ Yes ❑ No
Change in force or stream ❑ Yes ❑ No
Venereal Disease ❑ Yes ❑ No

Women (ONLY)

Last menstrual period ____________________
How many pregnancies? ____________________
How many full term? ____________________
How many miscarriages? ____________________
Age at first menstrual period ____________________
Age at first pregnancy ____________________
Did you breast feed? ❑ Yes ❑ No

Males (ONLY)

Testicle Pain ❑ Yes ❑ No
Prostate Problems ❑ Yes ❑ No

Signature ______________________________