

Reason for visit today: \_\_\_\_\_

Family physician: \_\_\_\_\_

**Check any MEDICAL DISORDER(S) which YOU have had or are being treated for:**

- |                                |                                |                        |
|--------------------------------|--------------------------------|------------------------|
| ----Anemia                     | ----Fibromyalgia               | ----Lupus              |
| ----Asthma                     | ----Heart Attack               | ----Depression         |
| ----Bleeding disorder          | ----Heart Disease              | ----Osteoarthritis     |
| ----Cancer (what type)_____    | ----Heart Murmur               | ----Prostate disease   |
| ----Bronchitis                 | ----Hepatitis                  | ----Seizures           |
| ----Cholesterol                | ----High Blood Pressure        | ----Sexual Dysfunction |
| ----Chronic Fatigue Syndrome   | ----HIV                        | ----Stroke             |
| ----Chronic Lung Disease       | ----Inflammatory Bowel Disease | ----Thyroid Disease    |
| ----Colitis                    | ----Infertility                | ----Tuberculosis       |
| ----Diabetes                   | ----Irritable Bowel Syndrome   | ----Ulcers             |
| ----Diverticulitis             | ----Kidney Disease             | ----Anxiety            |
| ----Endometriosis              | ----Kidney Stones              | ----Other _____        |
| ----Fibrocystic Breast Disease | ----Leukemia                   | _____                  |

**List any surgeries you have had:**

SURGERY	YEAR

**Personal Habits:**

Do you smoke? ---- Yes ----No

- If "Yes", how much? \_\_\_\_\_
- If "NO", have you smoked before? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcohol? ----Yes ----No If yes, how much? \_\_\_\_\_

Do you drink coffee---- Tea---- Sodas----

Do you exercise? ----Yes ----No

**Employment:**

Are you employed? ---- Yes ----- No

If yes, what is your job? \_\_\_\_\_

If retired, what was your job? \_\_\_\_\_

**Family History:**

Do you have any **immediate** family member ( brothers, sisters, parents) who has had a heart attack, heart surgery, stent etc. ?

-----Yes

-----NO

If YES, Please state relationship and approximate age when he/she had the problem:

1.

2.

3.

4.

5.

**Do you suffer from or experience :**

**General:**

Fever ---Yes ---No  
Weight loss ---Yes ---No  
Excessive fatigue ---Yes ---No

**GU:**

Burning with urination ---Yes ---No  
Loss of bladder control ---Yes ---No  
Blood in Urine ---Yes ---No  
Trouble starting to urinate ---Yes ---No  
Getting up at night to urinate ---Yes ---No  
Passing kidney stones ---Yes ---No

**Endocrine:**

Excessive thirst: ---Yes ---No  
Sensitivity to heat ---Yes ---No

Sensitivity to cold: ---Yes ---No

**Integumentary:**

Do you bruise easily: ---Yes ---No

Do you have frequent rash ---Yes ---No

Do you have dry skin ---Yes ---No

**Musculoskeletal:**

Joint or muscle ache ---Yes ---No

Joint swelling or redness ---Yes ---No

Gout ---Yes ---No

**Hematology:**

Do you bleed easily ---Yes ---No

**Respiratory:**

Hoarseness or change in voice    ---Yes    ---No  
 Loud snoring    ---Yes    ---No  
 Irregular breathing at night    ---Yes    ---No  
 Frequent cough or sputum    ---Yes    ---No  
 Coughing up blood    ---Yes    ---No  
 Wheezing    ---Yes    ---No  
  
 Shortness of breath    ---Yes    ---No

**If yes :**

During usual work    ---Yes    ---No  
 Climbing a flight of stairs    ---Yes    ---No  
 Which awakens you at night    ---Yes    ---No

**GI:**

Loss of appetite    ---Yes    ---No  
 Difficulty swallowing    ---Yes    ---No  
 Frequent heartburn    ---Yes    ---No  
 Frequent Nausea/Vomiting    ---Yes    ---No  
 Pain after eating    ---Yes    ---No  
 Constipation    ---Yes    ---No  
 Frequent Diarrhea    ---Yes    ---No  
 Blood in stools    ---Yes    ---No  
 Black stools    ---Yes    ---No

**Neurology:**

Hearing loss    ---Yes    ---No  
 Seizures    ---Yes    ---No  
 Dizziness    ---Yes    ---No  
  
 Trouble sleeping    ---Yes    ---No  
 Easy to fall asleep during  
    the day    ---Yes    ---No

**Cradiovascular:**

Fluttering in chest    ---Yes    ---No  
 Chest Pain    ---Yes    ---No  
 Fainting    ---Yes    ---No  
 Swelling of legs or feet    ---Yes    ---No