**Name: Age: Date:**

REV6.13.17

**I am here today because…**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social History**

[ ]  I am right handed. [ ]  I am left handed.

[ ]  I am ambidextrous.

I am…

 [ ]  Married [ ]  Widowed

 [ ]  Single [ ]  Divorced

I live with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  I have       children, age(s)

[ ]  I am…

 [ ]  retired. [ ]  a student.

 [ ]  disabled. [ ]  a homemaker.

 [ ]  unemployed.

 [ ]  part-time

 [ ]  full time

Diet

[ ]  Regular [ ]  Vegetarian [ ]  Diabetic

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  I do not smoke.

[ ]  I used to smoke. I quit            years ago after smoking            packs a day for            years.

[ ]  I am a smoker. I have smoked            packs a day for            years.

[ ]  I do not drink alcohol.

[ ]  I drink alcohol. I drink            drinks per ([ ]  day,
 [ ]  week, [ ]  month, [ ]  year).

[ ]  I do not drink caffeine.

[ ]  I drink            sodas / day,            cups of tea / day, and            cups of coffee / day

[ ]  I have never to my knowledge been exposed to harmful chemicals.

[ ]  I have been exposed to the following harmful chemicals:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Females only:

**Y N**

[ ]  [ ]  Do you use birth control? If yes, what kind?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My pharmacy is…**

[ ]  A local pharmacy:

Location:

Phone:

[ ]  A mail order pharmacy:

Contract ID:

**Privacy (HIPAA)**

Please send my consult notes to the following doctors:

**Primary Physician:**

**Others:**

 **Y N**

[ ]  [ ]  May we leave messages and test results on your **home** phone answering machine?

 **Y N**

[ ]  [ ]  May we leave messages and test results on your **cell** phone answering machine? If so, what is your mobile number?

 **Y N**

[ ]  [ ]  May we discuss your medical information, including test results, appointment times, and billing information with persons other than yourself? If so, who?

 **Y N**

[ ]  [ ]  May we contact you at work? If so, what is your work number?

 **Y N**

[ ]  [ ]  May we leave messages/results on your work phone?

 **Y N**

[ ]  [ ]  Do you have a Power of Attorney and/or Power of Attorney for Healthcare? If so, please provide their contact information and bring a copy of your documentation.

Name:

Address:

Phone:

**Y N**

[ ]  [ ]  Do you have a Living Will? If so, please provide a copy of your documentation.

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Y N**

[ ]  [ ]  Do you have a Pacemaker?

[ ]  [ ]  Do you have a Defibrillator?

**Past Medical History**

Please check if you have been diagnosed with any of the following medical conditions.

|  |  |
| --- | --- |
| [ ]  Asthma[ ]  Atrial Fibrillation[ ]  Balance Disturbance[ ]  Cancer (Type:                ) (Year:           )[ ]  Cardiac Murmur[ ]  Coronary Artery Disease[ ]  Diabetes (Type:                )[ ]  High Cholesterol[ ]  High Blood Pressure[ ]  Low Blood Pressure[ ]  High Thyroid[ ]  Low Thyroid[ ]  Lupus[ ]  Heart Attack  (Year:           )[ ]  Irregular Heartbeat | [ ]  Osteoporosis[ ]  Psoriasis[ ]  Rheumatoid Arthritis[ ]  Traumatic Accident (Year:           )[ ]  Brain Aneurysm (bleed)[ ]  Brain Hemorrhage (bleed)[ ]  Dementia[ ]  Headaches[ ]  Migraines[ ]  Multiple Sclerosis[ ]  Myasthenia Gravis[ ]  Neuralgia[ ]  Optic Neuritis[ ]  Parkinson’s Disease[ ]  Seizure Disorder[ ]  Stroke (Year:           )[ ]  TIA[ ]  Tremors |

**Surgical History**

[ ]  Appendectomy (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Brain Aneurysm Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Brain Tumor Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Cardiac Bypass Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Heart Valve Replacement (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Carotid Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_) [ ]  R [ ]  L

[ ]  Cataract Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_) [ ]  R [ ]  L

[ ]  Cervical (neck) Spine Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Knee Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_) [ ]  R [ ]  L

[ ]  Hernia (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Lumbar (low back) Spine Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Gallbladder Surgery (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Hysterectomy (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Total [ ]  Partial

[ ]  Tonsillectomy (Year: \_\_\_\_\_\_\_\_\_\_\_)

[ ]  Vasectomy (Year: \_\_\_\_\_\_\_\_\_\_\_)

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Surgical History**

Include **year**!

1.

2.

3.

4.

5.

**Hospitalizations**

Include **date** and **reason**! Do not include surgeries, please list above.

1.

2.

3.

4.

5.

**Review of Systems**

**Sleep** **Gastrointestinal**

[ ]  Snoring [ ]  Constipation

[ ]  Acting Out Dreams [ ]  Diarrhea

[ ]  Kicking in Sleep [ ]  Bowel Accidents

[ ]  Restless Legs

[ ]  Daytime Sleepiness **Genitourinary**

[ ]  Poor Sleep [ ]  Frequent UTIs

[ ]  Obstructive Sleep Apnea [ ]  Difficulty Urinating

[ ]  Uses CPAP [ ]  Bladder Accident

 [ ]  Kidney Stones

**Constitutional**

[ ]  Abnormal Weight Gain **Musculoskeletal**

[ ]  Abnormal Weight Loss [ ]  Low Back Pain

[ ]  Fevers [ ]  Left Arm Pain

[ ]  Night Sweats [ ]  Left Leg Pain

 [ ]  Right Arm Pain

**Eyes** [ ]  Right Leg Pain

[ ]  Vision Changes [ ]  Neck Pain

**Ears, Nose, Mouth and Throat Hematologic/Lymphatic**

[ ]  Dizziness [ ]  Blood Clot

[ ]  Hay Fever [ ]  Easy Bruising

[ ]  Hearing Loss

 **Allergic/Immunologic**

**Cardiovascular**  [ ]  Asthma

[ ]  Arrhythmia

[ ]  Chest Pain **Psychiatric**

[ ]  Syncope (Fainting) [ ]  Anxiety

 [ ]  Depression

**Respiratory** [ ]  Memory Loss

[ ]  Cough [ ]  Panic Attack

[ ]  Shortness of Breath

**Family History**

Please check the box if any member of your family has or had a medical history of the following. Leave blank if the answer is “No”.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Brother | Sister | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Spouse |
| Heart Disease |  |  |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |  |  |
| Bleeding Disorder |  |  |  |  |  |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |  |  |  |  |  |
| Lupus |  |  |  |  |  |  |  |  |  |  |
| Epilepsy/Seizures |  |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |  |  |  |  |
| Dementia/Alzheimer’s |  |  |  |  |  |  |  |  |  |  |
| Parkinson’s Disease |  |  |  |  |  |  |  |  |  |  |
| Multiple Sclerosis |  |  |  |  |  |  |  |  |  |  |
| Headaches |  |  |  |  |  |  |  |  |  |  |
| Tremor |  |  |  |  |  |  |  |  |  |  |

**MEDICINE LIST**

Please list all of the medications you are taking including over the counter medications and supplements. Please include the dosage and directions.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

14.

15.

16.

17.

18.

**DRUG ALLERGIES**

[ ]  I have no drug allergies.

1. Reaction:

2. Reaction:

3. Reaction:

4. Reaction:

5. Reaction:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: Date: