**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: