Date: _______________

Name: ____________________________ / _______________________ / ____________________ _______________
LAST FIRST MIDDLE (MAIDEN) DATE OF BIRTH

Briefly state the reason for this doctor visit: ____

____

PAST MEDICAL HISTORY – if your past medical history includes any of the following, please check

☐ Rheumatic Fever
☐ High blood pressure or hyptertension
☐ Stroke or Paralysis
☐ Kidney or Bladder Infection
☐ Tuberculosis or positive skin test
☐ Epilepsy
☐ Cancer – treated with radiation chemo
☐ Coughing up blood or mucus
☐ Bleeding tendency or blood disease
☐ Heart disease
☐ Arthritis, joint problems, or gout
☐ Lung or breathing problems
☐ Liver disease, Jaundice or Hepatitis
☐ Gallbladder Disease
☐ Thyroid Trouble

If you have, or have had, any illness or disease not included above, please list here.

REVIEW OF SYSTEMS: Please place a check mark before each of the following that apply to you.

☐ Abnormal shortness of breath with exercise or activity; spells of uncomfortable breathing or asthma
☐ 5 or more pounds lost or gained in past 6 months
☐ Fluid retention and/or ankle swelling
☐ Sleep propped up in bed
☐ Light-headedness, dizziness, vertigo, fainting spells
☐ Palpitations (thumping or racing heart)
☐ Heartburn, indigestion, gas, bloating, nausea, vomiting
☐ Periods of depression and/or anxiety
☐ Dental problems
☐ Problems with sexual function
☐ Chest pain
☐ Abdominal or back pain
☐ Unusual fatigue and/or lack of energy
☐ Frequent pain in legs with rest walking
☐ Coughing up blood or mucus
☐ Insomnia or trouble sleeping
☐ Nosebleeds or other bleeding problems
☐ Excessive or unexplained thirst

Indicate any symptoms you may be experiencing that are not listed above.

Please list all physicians you are currently seeing: __________________________ ___________________________

________________________________ ____________________________ ____________________________

To the best of my knowledge, the information contained above is accurate and complete.

____________________________________ ____________________________________
Patient's Signature Date

____________________________________ ____________________________________
Reviewing Physician Date