

GENERAL HISTORY-PLEASE FILL IN BOTH SIDES AND BRING TO OFFICE FOR VISIT

Patient Name: _____ DOB _____ Date _____

1. Reason for your consultation/visit today _____

Family Dr.'s office called and made appt. Patient called and made appt. at request of Family Dr. Patient called on own

2. Please indicate if you are having any current problems, signs or symptoms in any of the following areas:

- | | | |
|--|--|---|
| <input type="checkbox"/> General Wellness | <input type="checkbox"/> Lungs / Breathing | <input type="checkbox"/> Reproductive / Urinary |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Heart / Circulation | <input type="checkbox"/> Thyroid / Endocrine |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Muscles / Joints, Bones | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Ears, Nose, Throat | <input type="checkbox"/> Neurological | <input type="checkbox"/> Blood / Lymph |
| <input type="checkbox"/> Stomach / Digestion | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other _____ |

3. Are you currently taking: Aspirin / Coumadin / Plavix / Lovenox / Pletal / Aggrenox

4. Medication(s) (drugs, pills): _____

5. Past Medical History / Previous Surgeries / Dates: _____

6. Allergies to medications? Yes No If yes, please list allergy and what the reaction is (ex: rash, hives, etc.)

7. General / Social history of patient: Marital Status: Single Married Divorced Widow/Widower

Who lives with you? _____

Do you smoke? _____ How many packs a day? _____ For how many years? _____

Do you drink alcohol? _____ How many drinks per day? _____ Per week? _____ Per month? _____

History of Heart Disease (heart attack, heart failure) Yes No History of strokes? Yes No

Do you have any artificial heart valves, knee or hip joints? - If yes, please list specific area and date of procedure: _____

Do you have an AICD (Automated Internal Cardiac Defibrillator) or a pacemaker? Yes No

Do you have a history of renal or kidney disease? Yes No History of Diabetes? Yes No

History of Cancer? Yes, site _____ No History of High Blood Pressure? Yes No

8. What is the Health Status of your Family?

History of cancer for Mother, site: _____ Father, site: _____ Other, site: _____

9. Have you had any recent blood work, x-rays, sonograms or scans done relating to your visit today? Yes No

If yes, what did you have done, where and when: _____