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Name:____________________________**Date of Birth:**________________________

Referring Physician:____

Primary Physician:____

Current Medical Issues____

Past Medical Problems:____

Current Medications:____

Past Surgeries____

Medication Allergies;____

Family Medical History:
Are your Parents still alive?____

If yes, do they have any medical issues?____
If no, at what age did they pass?____________________________________
What was their cause of death?_____________________________________
Social History:
Are you married, divorced, widowed or single?__________________________
Employer:____
If retired, previous career?____
Do your smoke? yes/no **Do drink alcohol? Yes/no**
How Much?__________ **How much?**____________

Have you every had any of the following? Please circle.
General/Constitutional**:** Fever, fatigue, weakness, weight change
***Head, Eyes, Ears, Nose, Throat* -** Headaches. eye pain, loss of vision, double, blurred vision, flashing lights, spots, ringing in the ears, loss of hearing. nosebleeds, loss of sense of smell, sinusitis, and postnasal drip, sore tongue, dysphagia, loss of sense of taste, dry mouth, frequent sore throats, or hoarseness.
Cardiovascular**:** Chest pain, shortness of breath, heart racing, swelling of your feet, history of rheumatic fever or heart murmur, born with hole in your heart.
Respiratory**:** Chronic cough, coughing up blood, choking, wheezing or night sweats.
Gastrointestinal**:** Decreased appetite, nausea, vomiting, heartburn, stomach pain, diarrhea, constipation.
Genital/Urinary**:** Difficult urination, pain or burning with urination, hematuria, frequency, urgency, kidney stones.
Musculoskeletal**:** Arm, buttock, thigh or calf cramps, joint or muscle pain,muscle weakness or tenderness, joint swelling, neck pain, back pain or major orthopedic injuries.
Obstectrical: ________#live births________ #miscarriages, 1st day of last menstrual period_________________________.
Skin: Easy bruising, skin rash, hives,sudden hair loss, color changes in the hands or feet with cold.
Neurologic**:** Headache, dizziness, fainting, loss of consciousness, sensitivity or pain in the hands and feet, memory loss or seizures. migraine headaches
Psychiatric**:** Depression, anxiety, schizophrenia, bipolar disorder or thoughts of suicide
Endocrine**:** Intolerance to hot or cold temperature, flushing, increased thirst, increased salt intake.
Hematologic**:** Anemia, bleeding tendency or clotting tendency. Family history of clotting disorders
Immunologic**:** Allergic rhinitis, asthma, skin sensitivity, latex allergies, and sensitivity or history of immune deficiency
Vascular: Arterial surgery, venous surgery, vein stripping , phlebectomy, deep vein thrombosis(clot), non-healing leg sores, swollen legs or family history of varicose veins. Do you wear compression hose(Yes/No)?

General Office information:

Prior to today's appointment:

Was your appointment scheduled promptly?(if not please explain)____

When speaking with the office staff, in person or on the phone, were you treated with respect?____

Did we listen to you concerns?____

Did we answer all you questions?____

While in the office today:

Were you treated with respect?____

Were you attended to in a timely manner?_______________________________________

Were all your questions and concerns answered?___________________________________
Would you change anything about your experience?____
____

Thank you for your help in allowing us to serve you better!