



Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Age \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_  
Primary Care Physician (PCP): \_\_\_\_\_ PCP Phone: \_\_\_\_\_  
What is the reason for your consultation today? \_\_\_\_\_  
\_\_\_\_\_

Which, if any, areas of your body are troublesome to you? \_\_\_\_\_  
\_\_\_\_\_  
Have you seen any physician in the past for these issues? If so who and when? \_\_\_\_\_  
\_\_\_\_\_

**If you are female, please answer the following questions:**

1. Is there a chance you are currently pregnant? \_\_\_No \_\_\_Yes
2. # of pregnancies: \_\_\_\_\_ # of children: \_\_\_\_\_ ages: \_\_\_\_\_
3. Are you currently breast feeding? \_\_\_No \_\_\_Yes N/A
4. When was your last menstrual cycle? \_\_\_\_\_
5. Do you take birth control pills? \_\_\_No \_\_\_Yes \_\_\_N/A
6. Do you use hormone replacement therapy? \_\_\_No \_\_\_Yes \_\_\_N/A

**Past Medical History (Please circle the appropriate answer):**

1. Previous Hospitalizations? \_\_\_No \_\_\_Yes : If yes, reason for hospitalization and year :  
\_\_\_\_\_
- Previous Surgeries? \_\_\_No \_\_\_Yes: If yes, reason for surgery and year :  
\_\_\_\_\_
2. Are you presently under the care of a physician? \_\_\_No \_\_\_Yes  
If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

**Do you have a history of any of the following?**

- |  |                                       |
|--|---------------------------------------|
| 1. Heart disease/heart attack/stress test ___No ___Yes   | 10. Blood Disorder ___No ___Yes       |
| 2. Cancer ___No ___Yes                                   | 11. Tuberculosis (TB) ___No ___Yes    |
| 3. Mitral valve prolapse ___No ___Yes                    | 12. Kidney disease ___No ___Yes       |
| 4. Thyroid ___No ___Yes                                  | 13. Diabetes ___No ___Yes             |
| 5. High blood pressure ___No ___Yes                      | 14. HIV/AIDS ___No ___Yes             |
| 6. Fear of Needles ___No ___Yes                          | 15. History of fainting ___No ___Yes  |
| 7. Lung disease/asthma/bronchitis/emphysema ___No ___Yes | 16. Anemia ___No ___Yes               |
| 8. Liver Disease/ Hepatitis(A,B,C) ___No ___Yes          | 17. Elevated cholesterol ___No ___Yes |
| 9. Clotting/ Bleeding Disorder ___No ___Yes              | 18. Osteoporosis ___No ___Yes         |



**Review of Symptoms: Do you ever experience any of the following?**

Chest pain	Yes	No
Knee/Hip pain	Yes	No
Shortness of breath	Yes	No
Back Pain	Yes	No
Palpitations	Yes	No
Excessive scarring	Yes	No
Irregular heart beat	Yes	No
Low blood pressure	Yes	No
Visual Problems	Yes	No
Seizures	Yes	No
Depression/Memory Loss	Yes	No

**If you have answered yes to any of the above, please explain:**

\_\_\_\_\_

**Are you currently under a physician's care for any of the above? \_\_\_No \_\_\_Yes: If yes, please explain:**

\_\_\_\_\_

**Family History Do any of your family members have the following?**

Blood clots/pulmonary embolism	Yes	No
Blood coagulation disorder	Yes	No
Heart disease/heart attack	Yes	No
Stroke	Yes	No

**Social History**

Do you exercise regularly? Yes No

Type of exercise: \_\_\_\_\_

Do you smoke? \_\_\_No \_\_\_Yes: \_\_\_less than 1pk/ day \_\_\_1pk/day \_\_\_more than 1pk/day

Do you drink alcohol? \_\_\_No \_\_\_Yes: \_\_\_1-2 drinks/wk \_\_\_ 3-5/week \_\_\_5+/week

Occupation: \_\_\_\_\_

**Medications : (Please list all types including herbals and over the counter medications)**

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

**Allergy History:**

No known allergies

**Medication Allergies:**

Names:\_\_\_\_\_ Reaction:\_\_\_\_\_ Name:\_\_\_\_\_ Reaction:\_\_\_\_\_

Names:\_\_\_\_\_ Reaction:\_\_\_\_\_ Name:\_\_\_\_\_ Reaction:\_\_\_\_\_

Other Allergies (food, seasonal, etc?) \_\_\_Yes \_\_\_No

Latex allergy? \_\_\_Yes \_\_\_No

Local Anesthesia allergy? \_\_\_Yes \_\_\_No

Is there any other information you feel would be important for us to know?\_\_\_\_\_

\_\_\_\_\_

Patient Signature:\_\_\_\_\_