DATE:_____

PATIENT NAME:_____

DATE OF BIRTH:_____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED STUDENT CHILD

OCCUPATION:_____

REASON FOR VISIT:_____

PRESENT SYMPTOMS:_____

PLEASE LIST THE NAME AND CITY OF YOUR PRIMARY PHARMACY:

NAME:_____CITY:_____

ARE YOU TAKING ANY MEDICATIONS NOW? (THIS INCLUDES PRESCRIPTIONS, OVER THE COUNTER, AND HERBAL MEDICATIONS):

YES NO

NAME OF MEDICATION	DOSAGE	HOW OFTEN

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

NAME OF MEDICATION	TYPE OF REACTION

SOCIAL HISTORY

Do you use any tobacco products of any kind? YES NO

Approximately how much? _____ How many years? _____ How long ago did you quit? _____

Do you consume alcohol? YES NO

Approximately how much? _____How many years? _____ How long ago did you quit? _____

NAME: _____

MEDICAL HISTORY

HAVE YOU EVERY SEEN A HEART DOCTOR OR CARDIOLOGIST? Yes No

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING PROBLEMS? (CIRCLE ALL THAT APPLY)

CANCER: YES NO IF YES, WHAT KIND? _____

LIVER:	**YES**	**NO**	**EMPHYSEMA:**	**YES**	**NO**
ASTHMA:	**YES**	**NO**	**HIV:**	**YES**	**NO**
KIDNEY DISEASE:	**YES**	**NO**	**SEIZURES:**	**YES**	**NO**
ANEMIA:	**YES**	**NO**	**REFLUX:**	**YES**	**NO**
STROKE:	**YES**	**NO**	**ULCERATIVE COLITIS:**	**YES**	**NO**
COPD:	**YES**	**NO**	**HEART ATTACK:**	**YES**	**NO**
SLEEP APNEA:	**YES**	**NO**	**ANXIETY:**	**YES**	**NO**
HIGH CHOLESTEROL:	**YES**	**NO**	**DIABETES:**	**YES**	**NO**
HIGH BLOOD PRESSURE:	**YES**	**NO**	**HYPERTHYROIDISM:**	**YES**	**NO**
HEART DISEASE:	**YES**	**NO**	**CONGESTIVE HEART FAILURE:**	**YES**	**NO**

OTHER CONDITIONS NOT LISTED: _____

PLEASE LIST ALL SURGERIES AND INCLUDE DATES (APPROXIMATE):

PROCEDURE/SURGERY	**DATE**
_____	_____
_____	_____
_____	_____
_____	_____

DO YOU HAVE A PACEMAKER OR DEFIBULATOR OR OTHER CARDIAC DEVICE? YES NO

HAVE YOU EVER HAD A HEART CATH OR HEART PROCEDURE/SURGERY? YES NO

FAMILY HISTORY

DOES ANY MEMBER OF YOUR FAMILY HAVE PROBLEMS WITH ANY OF THE FOLLOWING? IF SO, PLEASE LIST RELATIONSHIP TO PATIENT

	MOTHER			**FATHER**		
HEART DISEASE	**YES**	**NO**		**YES**	**NO**	
HIGH BLOOD PRESSURE	**YES**	**NO**		**YES**	**NO**	
ASTHMA	**YES**	**NO**		**YES**	**NO**	
STROKE	**YES**	**NO**		**YES**	**NO**	
DIABETES	**YES**	**NO**		**YES**	**NO**	
CANCER	**YES**	**NO**	**TYPE_____**	**YES**	**NO**	**TYPE_____**
DECEASED	**YES**	**NO**		**YES**	**NO**	
CAUSE OF DEATH: _____				**CAUSE OF DEATH: _____**		

PATIENT NAME: _____

Reference: ISO 9001: 2015, Formulation date: 8/16, Revision: 8/16, 9/16,11/16 Approved by: T.Gipson, RN, Clinic nurse manager

REVIEW OF SYSTEMS

(PLEASE CIRCLE ALL THE FOLLOWING SYMPTOMS YOU RECENTLY HAD)

GENERAL HEALTH:
FEVER CHILLS UNINTENTIONAL WEIGHT LOSS SLEEPING PROBLEMS

FATIGUE DIZZINESS WEIGHT GAIN

LUNG AND RESPIRATORY:
FREQUENT NONPRODUCTIVE COUGH FREQUENT PRODUCTIVE COUGH SHORTNESS OF BREATH

WHEEZING

HEART AND CIRCULATION:
BLACKING OUT OR FAINTING CHEST PAINS IRREGULAR HEARTBEAT SWELLING OF ANKLES

CHEST DISCOMFORT TROUBLE BREATHING ON EXERTION CALF OR LEG PAIN

GASTROINTESTIONAL:
ABDOMINAL PAIN DIARRHEA BLOATING CONSTIPATION HEARTBURN

NAUSEA VOMITING LOSS OF APPETITE

GENITOURINARY:
BLOOD IN URINE PAINFUL URINATION

SKIN/NAILS:
ABSCESS CYST INGROWN TOENAIL KELOID LESION MOLE

SKIN TAG TUMOR/MASS ULCER WART BREAST MASS/PAIN

ENDOCRINE:
EXCESSIVE HUNGER EXCESSIVE THIRST EXCESSIVE SWEATING

INCREASED/ DECREASED ENERGY LEVEL UNWANTED WEIGHT CHANGE

PLEASE LIST ANY OTHER SYMPTOMS YOU CURRENTLY HAVE THAT ARE NOT LISTED ABOVE: