1. Who encouraged you to seek a primary care physician? (e.g. spouse, Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

friend, hospital, your own concerns)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. What do you hope to achieve from this consultation?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. Do you currently smoke: cigarettes cigars pipe marijuana

How much do you currently smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. If you don’t smoke currently, describe your past smoking habits: how much & how long?

 Never smoked \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. Have you ever been exposed to tuberculosis? Yes No
2. Tuberculosis test (PPD skin test) history:

PPD results: Never done Year:\_\_\_\_\_\_\_\_\_\_\_\_ Normal Abnormal

1. Which of the following are you currently or recently experiencing?

Yes No Respiratory Yes No ENT

 cough sneezing

 sputum production nasal congestion

 coughing up blood nasal decongestant

 trouble breathing (e.g. Afrin, 4-way)

 with exertion post-nasal drip

 trouble breathing recurring nose bleeds

 lying down frequently clear throat

 waking up at night hoarse voice

 with difficulty breathing sore throat

 wheezing frequent bad breath

 chest tightness impaired smell

 impaired taste

Yes No Cardiovascular loud disruptive snoring

 chest pain or pressure stop breathing in sleep palpitations hearing loss

 rapid heart beat

 slow heart beat

 heart murmur

Yes No Cardiovascular continued Yes No Constitutional

 swollen feet/legs loss of appetite

 recent fainting spells weight loss

 weight gain

Yes No Allergic & Immunologic chills or fevers

 immune problem heavy sweating at night

 serious or daytime fatigue/tired

 life-threatening allergy daytime sleepiness autoimmune disorder

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

8. What hazardous materials, fumes, dusts, chemicals, etc. have you been exposed to?

 exotic brids or bird feathers grain dust moldy hay

 hot tub/spa at home asbestos beryllium

 sandblasting welding heavy metals

 pesticides solder baking flour dust

9. Check or list any of these medical problems you have now or in the past:

 asthma Nose/Sinus allergy (pollen,plants,animals,dust, etc.)

 eczema Positive allergy testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ allergy shots: When & What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 COPD (e.g. chronic bronchitis, bronchiectasis, emphysema, cystic fibrosis)

 pulmonary fibrosis asbestos sarcoidosis

 tuberculosis valley fever (cocci)

 DVT (blood clot in leg) pulmonary embolism (blood clot in lung)

 Pulmonary hypertension

 Other lung disease (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Check any of these medical problems you have now or in the past:

 sleep apnea restless leg syndrome narcolepsy

 depression anxiety disorder bipolar disorder

 schizophrenia TMJ disorder dentures

 migraine headaches seizure/epilepsy prostate enlargement

 GERD/acid reflux diabetes (blood sugar) hypertension (blood pressure)

 choletsreol/triglyceride/lipid disorder

 atrial fibrillation abnormal heart rhythm heart attack

 congestive heart failure cardiomyopathy stroke or TIA

 iron deficiency anemia

 AIDS/HIV infection Alcohol abuse Drug abuse

11. Check or list any of these medial problems you have now or in the past:

 stomach ulcer ulcerative colitis or Crohn’s diverticulitis

 yellow jaundice gallstones pancreatitis

 hepatitis or other liver disease (provide details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 osteoarthritis gout lupus

 rheumatoid arthritis other arthritis scleroderma

 kidney stones other kidney disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 thyroid disorder (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 cataracts macular degeneration glaucoma

12. Cancer/malignancy (check all past or present)

 Lung Liver Prostate Leukemia

 Colon Bladder Kidney Lymphoma

 Breast Kidney Thyroid Melanoma

 Other cancer or tumors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Check or list all childhood diseases you recall having:

 Whooping cough Polio

 Rheumatic fever Chicken Pox

14. Other major medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Check or list all surgery you remember having:

 tonsils removed adenoids removed sinus surgery

 nasal septum repaired soft palate/uvula removed tongue surgery

 jaw surgery heart bypass heart valve replaced

 heart stent or angioplasty other stent or angioplasty gallbladder removed pacemaker or defibrillator lung surgery ulcer surgery hiatal hernia surgery appendix surgery hysterectomy hip replacement knee replacement prostate surgery cataract surgery retinal surgery

Other surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

16. List all of the medications you take including asthma inhalers, nasal sprays, topical medications and as needed medications (Or Attach A List Of Your Medications):

|  |  |  |
| --- | --- | --- |
| **Medicine** | **Dose or Strength** | **When & How Often Taken** |
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17. List all of the over-the-counter medicine you take, including vitamins, minerals, supplements, herbals:

|  |  |
| --- | --- |
| 1. | 11. |
| 2. | 12. |
| 3. | 13. |
| 4. | 14. |
| 5. | 15. |
| 6. | 16. |
| 7. | 17. |
| 8. | 18. |
| 9. | 19. |
| 10. | 20. |

18. When and where did you get your last vaccines:

Vaccine Date Where received

Flu (influenza) vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumovax (pneumonia vaccine) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pertussis (whooping cough vaccine) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Varicella vaccine (shingles, chicken pox) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tetanus vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other adult vaccine (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

19. List any medications you are sensitive to, allergic to or react badly to:

Name of Medicine Type of Reaction (e.g. hives, breathing problem)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20. Have you had an x-ray test where dye (contrast) was injected into your vein or artery?

 Yes No

 If yes, describe any side effects or allergic reaction to the dye: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

21. Have you ever received chemotherapy or radiation therapy? Yes No

 When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

22. Have you ever donated blood? Yes No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23. Have you ever received a blood transfusion? Yes No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. Do you think you might be at risk for HIV infection or AIDS? Yes No

25. Are you: married or in a long term relationship widowed separated divorced

26. Who lives at home with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27. a. Where did you grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 b. Where else have you lived and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 c. How long have you lived locally? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

28. What is your highest level of school attended? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29. Are you currently? Self-employed employee unemployed disabled retired

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

30. What is your current or most recent occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

31. What other type of work have you done in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

32. Describe any military experience? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

33. List travel outside the United State in the past 5 years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

34. Describe your diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

35. Describe your usual exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

36. Do you drink: Beer How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_ per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Wine How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_ per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hard Liquor How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_ per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

37. If you don’t drink alcohol currently, describe past alcohol consumption: how much & how long?

 Never drank alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

38. Do you drink any caffeinated beverages?

 Coffee How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 tea How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 cola/mountain dew How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 energy drinks How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

39. List any pets at home, including birds, rodents, reptiles, etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

40. List family members with the following problems:

|  |  |
| --- | --- |
| sleep apnea loud snoring | restless left syndrome |
| narcolepsy | long-term insomnia |
| depression | anxiety disorder |
| high blood pressure | diabetes |
| high cholesterol or triglycerides | heart attack or clogged arteries |
| congestive heart failure | stroke |
| pulmonary hypertension | pulmonary fibrosis |
| asthma | nasal allergies, e.g. pollen, dust, cat allergy |
| blood clot problems | bleeding disorder |
| dementia or Alzheimers | Parkinson’s |

41. Complete the following about your family medical history:

 I am adopted and do not know anything about my biological family medical problems

 Age Alive? Cause of death Major health problems

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Father |  |  |  |  |
| Mother |  |  |  |  |

Complete this table for brothers, sisters, sons, daughters:

 (please list them even if healthy)

 Relative Age Alive? Cause of death Major health problems

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
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42. Review of Systems

 (see question 3 for Pulmonary, ENT, Cardiac, Constitutional, Allergic/immunologic)

How tall are you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you lost height due to osteoporosis or other reasons? Yes No

 If so, how much height have you lost from your tallest? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your neck size? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your most recent weight? \_\_\_\_\_\_\_\_\_\_\_

How much did you weigh 1 year ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5 years ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 10 years ago? \_\_\_\_\_\_\_\_\_\_\_\_ at age 21? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you ***currently experiencing***

Yes No Eye Yes No Neurologic

 blurry vision frequent headaches loss of vision recent seizure itchy eyes recent stroke watery eyes difficulty speaking dry eyes memory loss eye pain hand tremor sensation of room spinning

Yes No Musculoskeletal muscle pain Yes No Gastrointestinal Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ nausea or vomiting leg cramps at night difficulty swallowing joint pain pain when swallowing Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ belly pain joint stiffness heart burn Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ acid reflux joint swelling diarrhea Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ blood in stool dark black stools

Yes No Integument

 current skin rash

 current skin cancer

 frequent itching

 Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review of Systems (continued)

Are you ***currently experiencing***

Yes No Psychiatric Yes No Endocrine

 depression poor tolerance of cold

 anxiety or nervousness poor tolerance of heat

 hallucinations extreme thirst paranoid thoughts loss of interest in sex

 claustrophobia poor sexual function

Yes No Heme & Lymphatic Yes No Genitourinary System anemia: difficult – slow urination

 Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ frequent urination iron deficiency urinate at night? swollen glands: How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ blood in urine easy bleeding easy bruising

Female Reproductive

How many pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many miscarriages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you still menstruating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unusually prolonged or heavy bleeding? Yes No

Is there anything else you want us to know about your medical history?

Durable Power of Attorney for Health Care

If you are unable to make your own medical decisions, who should we contact as a representative to speak for you?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_