Past Medical History.

Please provide us with the list of your medical problems.

Please indicate year of onset or when you became aware of it and year of resolution (if resolved)

	Problem	Started	Resolved
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			

Patient's Name:_____

Please provide the list of surgeries you had, if any. Please include arterial angioplasties and stenting of the arteries.

	Surgery	Year Performed
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		

Patient's Name:_____

Family History

Please provide us with your family history.

Put a checkmark if person is alive.

Put current age if person is alive or age at death if the person has passed away.

If you know the age (approximate is OK) at onset of the problem please write it in, otherwise put checkmark.

If there are other relatives who have/had conditions listed below, please add them in the empty spaces at the end of the table.

	Alive	*Age*	*Kidney failure/ Dialysis*	*Stroke/ TIA*	*High Blood Pressure*	*Heart Attack*/ age*	*High Cholesterol*	*Diabetes*	*Other*
Mother									
Father									
Brother1									
Brother2									
Brother3									
Brother4									
Sister1									
Sister2									
Sister3									
Sister4									
Son1									
Son2									
Son3									
Daughter1									
Daughter2									
Daughter3									

*Also please include Coronary Bypass surgery, Coronary strents, Angioplasty

Patient's Name:_____

Social History

Are/were you married?_____

Do/did you work?_____

Where?_____

What kind of work do you do/did there?_____

Are you or have you been exposed to lead, cadmium, mercury or other heavy metals at your work or hobby?_____

Habits

Tobacco:

Do you smoke or did you smoke?_____

How much?_____

At what age did you start smoking?_____

At what age did you quit?_____

Alcohol:

Do you drink alcohol?_____

How much?_____

How frequently?_____

Have you ever drank moonshine (self-distilled whiskey)? _____

Patient's Name:_____

Caffeinated beverages:

Do you drink coffee, tea, hot chocolate, caffeinated sodas?_____

How much?_____

Salt:

Are you on a low salt diet?_____

Do you buy prepared foods?_____

Do you have a salt shaker on your table?_____

Over the counter medications and supplements:

Are you taking any over the counter anti-inflammatory medications (Ibuprofen, Motrin, Advil, Naprosyn, Aleve, aspirin) or headache medications?_____

How many pills per day?_____

For how many years?_____

Are you taking any herbal or holistic medications?_____

Please write down the names:_____

Are you using any medications/supplements to help weight loss?_____

Please write down the names:_____

Are you using cocaine or methamphetamines?_____

Please describe your usual exercise routine: _____

Patient's Name:_____

Allergies:

Do you have any allergies to food or medications?
If no, proceed to the next page.

Please describe medication and food allergies:

Medication	Year when occurred	Nature of allergic reaction (rash, wheezing, shock, etc.)	For office use, please leave blank

Are you allergic to:

Name of medication/ food:	Yes	No	Not Sure
Penicillin			
Aspirin			
Iodine			
Seafood			
Blood pressure medications			

Patient's Name:_____

List of Current Medications

Please list all the medications, including over-the-counter medications that you are currently taking and how many times a days are you taking it:

	Medication Name	**How Many Times a Day**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		

Patient's Name:_____

Review of Systems:

Please fill in answers into the table by placing checkmark in appropriate field:

	Do you have or recently had:	**Yes**	**No**	**Not sure**
1	Fever, chills or night sweats			
2	Weight loss			
3	Worsening fatigue			
4	Skin rash of any kind			
5	Hearing problems			
6	Inflammation of the eye			
7	Bloody/discolored sinus drainage			
8	Strep throat			
9	Coughing up blood			
10	Worsening shortness of breath			
11	Chest pain			
12	Fast or irregular heart beats			
13	Increase in the size of the abdomen			
14	Bloody diarrhea			
15	Increased frequency of urination			
16	Blood in the urine			
17	Coke-colored urine			
18	Swelling of the ankles			
19	Swelling, pain and warmth of the joints			
20	Persistent numbness and/or pain in the feet			

Have you ever had:	Yes	No	Not Sure
Blood transfusion			
Jaundice			
Hepatitis			
Lupus			
Risk factors or exposure to HIV			
Kidney Stones			
Gout			

Patient's Name:_____

Hypertension questioner:

Please answer these questions if you are referred for hypertension management or have hypertension.

When was the **last time** you were told that your BP is **normal** (while not on medications to treat blood pressure)?_____

When was the **first time** you were told that your BP is **NOT normal**?_____

What was the typical BP reading 1 year ago?_____

What was the typical BP reading 5 years ago?_____

What was the typical BP reading 10 years ago?_____

Please take your time over the next several days to check and record in the table below your BP at specified times of the day (if you own or can borrow one for a few days a blood pressure monitor).

Date	BP in AM **before** meds	BP in AM 2 hours **after** AM meds	BP in PM **before** meds and/or dinner	BP in PM 2 hours **after** meds and/or dinner	BP before **bedtime**

Please bring all your prescriptional, over-the counter, herbal medications and other supplements to your appointment.
Please bring your blood pressure monitor to your appointment to be checked for accuracy.

Patient's Name:_____

Please fill this form if you were told you have protein or blood in your urine

Have you ever had Urine Analysis (UA) performed?
UA is usually performed as part of the screening examination, regular physical exam or to evaluate specific complaints. UA is almost always performed during pregnancy, usually several times.

If you have not had or do not remember UA performed go to the next page.

When was your first UA performed?_____

When and where was your last UA performed?_____

How often have you had UA performed in between?_____

When was the last time you had **normal** UA?_____

When was the **first time** you were told that your UA was **NOT normal**?___
_____

Who was your doctor at that time?_____

What was not normal in the urine?	Yes	No	Not sure
Protein in the urine			
Blood in the urine			
White blood cells (sign of infection) in the urine?			
Anything else abnormal in the urine?			

What was not normal in the urine?	Yes	No	Not sure
Protein in the urine			
Blood in the urine			
White blood cells (sign of infection) in the urine?			

Patient's Name:_____