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Please complete this form and return to our office prior to your appointment. Please fax it to the appropriate fax # for your location. If unable to fax, please bring this form with you to your appointment.

Last Name:					
First Name:					
Date of Birth:					
Age:					
Home Address:					
Ethnicity/Race: (Optional)					
Marital Status:	☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Other**				
Occupation (or prior occupation if not working)					
Who referred you to me?					
What is the reason for the consultation?					
List your physicians: **Use additional pages if needed**		**Name**	**Specialty**	**Address**	**Phone #**
****Check box if provider to receive a copy of today's consultation**	☐		Pulmonologist		
	☐		Cardiologist		
	☐		Medical Oncologist		
	☐		Radiation Oncologist		
	☐		Gastroenterologist		
	☐		Other		

Patient name: _____ Date of birth: _____

Pharmacy	Name	Address	Phone#	Fax #

Medications

Are you currently taking any medication? If "yes", please list the medication(s), dosage and times taken per day. Please add a separate sheet if required	☐ **Yes** ☐ **No** **Name of medication** / **Dosage** / **Times taken per day**

Allergies

Are you allergic to any medications? If "yes", please name the medications	☐ **Yes** ☐ **No**
Do you have a **latex allergy**?	☐ **Yes** ☐ **No**
Do you have other allergies? (such as food or environmental) If yes, please list	☐ **Yes** ☐ **No** **Other allergies:_____**

Have you taken any Aspirin, Advil, Nuprin (or similar medications) in the last 7 days? If "yes", what is the name of the medication?	☐ **Yes** ☐ **No** ☐ **Aspirin** ☐ **Advil** ☐ **Aleve** ☐ **other _____**

Medical History- check all that apply and note date diagnosed

☐ **Anemia**	☐ **Diabetes – Type 2**	☐ **Kidney failure**	☐ **Scleroderma**
☐ **Anesthesia Complications**	☐ **Diverticulitis** ☐ **Fibromyalgia**	☐ **Kidney stones**	☐ **Seizure disorder**
☐ **Angina**	☐ **Fibroid Tumors**	☐ **Liver disease**	☐ **Sickle cell disease**
☐ **Anxiety**	☐ **Gallstones**	☐ **Lupus**	☐ **Swelling/edema**
☐ **Arrhythmia**	☐ **Gallbladder inflammation**	☐ **Multiple sclerosis**	☐ **Stroke (CVA)**
☐ **Atherosclerosis**	☐ **Gastric acid reflux**	☐ **Myasthenia gravis**	☐ **TIA**
☐ **Autoimmune Disease**	☐ **Gastric ulcer**	☐ **Multiple Myeloma**	☐ **Transplant** **Specify: _____**
☐ **Back problems**	☐ **Gastric bleeding**	☐ **Neuropathy**	☐ **Thyroid disorder**
☐ **Bleeding/Clotting disorder**	☐ **Gout**	☐ **Obesity**	☐ **Tuberculosis**
☐ **Cancer – type_____**	☐ **Heart attack (MI)**	☐ **Osteoarthritis**	☐ **Ulcerative colitis**
☐ **Chronic Bronchitis**	☐ **Hepatitis type: _____**	☐ **Osteoporosis**	☐ **Urinary tract infection**
☐ **Chronic Renal Failure**		☐ **Obstructive sleep apnea**	☐ **Valvular heart disease**
☐ **Cirrhosis**		☐ **Joint replacement**	
☐ **Claudication**			

☐ **Carotid disease** ☐ **Congestive heart failure** ☐ **Crohn's disease** ☐ **Deep Vein Thrombosis (Blood Clots)** ☐ **Depression** ☐ **Diabetes – Type 1**	☐ **High blood pressure** ☐ **Hyperthyroidism** ☐ **High cholesterol/lipids** ☐ **HIV** ☐ **Irritable bowel syndrome** ☐ **Kidney disease**	**Specify: _____** ☐ **Pancreatitis** ☐ **Paraplegia/Quadreplegia** ☐ **Radiation treatment/exposure** ☐ **Raynard's syndrome** ☐ **Rheumatoid arthritis**	☐ **Vasculitis** ☐ **Vericose veins** ☐ **Venous stasis**

Other medical history: please describe

Patient name: _____ Date of birth: _____

Past Surgical History- check all that apply and note the side of surgery and the exact date diagnosed

☐ **Amputation**	☐ **Gastric banding**
☐ **Angioplasty**	☐ **Hemorrhoids surgery**
☐ **Aneurysm repair**	☐ **Hernia repair – site:**
☐ **Arterial bypass**	☐ **Hysterectomy**
☐ **Appendectomy**	☐ **Joint replacement – site:**
☐ **Bronchoscopy**	☐ **Dialysis access placement – site/type:**
☐ **Breast surgery**	☐ **Transplant – type:**
☐ **Bunion removal**	☐ **Nephrectomy**
☐ **Bypass surgery (CABG)**	☐ **Nissen fundoplication**
☐ **Cancer surgery**	☐ **Pacemaker**
☐ **Cardiac surgery**	☐ **Pancreas surgery**
☐ **Cataract surgery**	☐ **Parathyroidism**
☐ **Carotid surgery**	☐ **Lung surgery**
☐ **Carpel Tunnel syndrome**	☐ **Bone/Joint surgery – specify:**
☐ **Charcot reconstruction**	☐ **Prostate surgery (TURP)**
☐ **Cosmetic surgery**	☐ **Spine surgery**
☐ **Cholecystectomy**	☐ **Vein surgery**
☐ **Cesearean section**	☐ **Valve replacement – type:**
☐ **Gastric Bypass**	

Family History

Do you have a family history of the following disease processes: cancer, high blood pressure, stroke, heart disease, or diabetes?	☐ **Yes** ☐ **No**

If "yes", list relative, age and initial diagnosis:

Relative	Paternal/Maternal (P) (M)	Diagnosis / Age at diagnosis	Current Status of Relative?	If deceased, cause and age of death
	☐ **P** ☐ **M**		☐ **Living** ☐ **Deceased**	
	☐ **P** ☐ **M**		☐ **Living** ☐ **Deceased**	
	☐ **P** ☐ **M**		☐ **Living** ☐ **Deceased**	

	☐ P ☐ M		☐ Living ☐ Deceased	
	☐ P ☐ M		☐ Living ☐ Deceased	

Social History			
Have you ever smoked?	☐ **Yes** ☐ **No**		
If "yes" indicate duration in years:	Year started	Year stopped	# Packs/day
Do you exercise regularly?	☐ **Yes** ☐ **No**		

Do you eat or drink foods containing caffeine? (for example: coffee, tea, soda or chocolate?)	☐ **Yes** ☐ **No**
If "yes" list average daily consumption:	
Do you drink alcohol?	☐ **Yes** ☐ **No**
If "yes", average number of alcoholic drinks/day:	
Do your religious beliefs impact your utilization of health services (e.g. Jehovah's witness)	

Patient name: _____ Date of birth: _____

Review of Systems

Please check any of the symptoms that you are experiencing NOW.

General Symptoms
☐ Loss of appetite
☐ Weight loss/gain
Specify amount gained/lost in last 3 months
☐ Fevers or chills
☐ Dizziness
☐ Night Sweats
☐ Other: _____

Respiratory Symptoms
☐ None
☐ Shortness of breath
☐ Shortness of breath with activity
☐ Shortness of breath at rest
☐ Shortness of breath lying flat
☐ Coughing up blood or sputum
☐ Wheezing
☐ Other: _____

Gastrointestinal Symptoms
☐ None
☐ Abdominal pain
☐ Bloos in stool
☐ Change in bowel habits
☐ Difficulty/pain with swallowing
☐ Hiatal hernia
☐ Indigestion/GERD
☐ Vomiting blood
☐ Other: _____

Cardiovascular Symptoms
☐ None
☐ Angina
☐ Calf pain or cramps when walking
☐ Heart murmur
☐ Irregular heart beat
☐ Wake up out of breath (PND)
☐ Other: _____

Genitourinary Symptoms
☐ None
☐ Bladder cancer
☐ Bladder/Kidney infections
☐ Blood in urine
☐ Difficulty urinating
☐ Enlarged prostate
☐ Prostate cancer
☐ Other: _____

Hematologic Symptoms
☐ None
☐ Anemia
☐ Bleeding/clotting disorder
☐ Depressed immune system
☐ Swollen lymph nodes
☐ Other: _____

Musculoskeletal Symptoms
☐ None
☐ Back/spine problems
☐ Joint pain/stiffness
☐ Osteoporosis
☐ Other: _____

Neurological Symptoms
☐ None
☐ Difficulty with speech
☐ Numbness in arms/hands/legs/feet
☐ Seizures
☐ Stroke
☐ Weakness in arms/hands/legs/feet
☐ Other: _____

Gynecologic Symptoms
☐ None
☐ Abnormal bleeding
☐ Ovarian/Uterine tumors
☐ Other: _____

Patient name: _____ Date of birth: _____

Additional information		
Please sign your name:		***Date:***
Reviewed with patient	_____ _____ ***Provider*** ***Date***	

Thank you for taking the time to complete and return this form. Please initial the bottom right corner of each page before returning to our office.