What is the purpose of your visit today?

MEDICAL HISTORY

What medical problems do you have? Please include anything for which you have been hospitalized, seen a physician or take medication:

Do you have or have you ever experienced any of the following? **PLEASE CIRCLE**

Anemia	Asthma	Atrial Fibrillation	Bleeding Problems
Blood Clots	Cancer	COPD/Emphysema	Diabetes
Heart Attack	Heart Failure	HIV/AIDS	Hepatitis
High Blood Pressure	High Cholesterol	Liver Disease	Pancreatitis
Stomach Ulcers	Colitis	Thyroid Problems	Other:

Do you take any blood thinners (aspirin, ibuprofen, fish oil, Coumadin, etc.)? YES NO I DON'T KNOW
Do you take any steroids, biologic infusions, or immunosuppressants? YES NO I DON'T KNOW
Are you vaccinated for COVID-19? YES NO If yes, Dates:_____
Booster? YES NO

SURGICAL HISTORY

Please list the type of operation, the year it was performed, the hospital and the name of your surgeon:

FAMILY HISTORY

Does anyone in your family have any of the following? **PLEASE CIRCLE**

Anemia	Asthma	Atrial Fibrillation	Bleeding Problems
Blood Clots	Cancer	COPD/Emphysema	Diabetes
Heart Attack	Heart Failure	HIV/AIDS	Hepatitis
High Blood Pressure	High Cholesterol	Liver Disease	Pancreatitis
Stomach Ulcers	Colitis	Thyroid Problems	Other:

HABITS AND SOCIAL HISTORY

Do you use chewing tobacco? Yes No
Do you currently smoke? Yes No For how many years?
Do you currently vape? Yes No For how many years?
If no, did you smoke in the past? Yes No For how many years?
If yes, what do/did you smoke? Cigarettes Cigar Pipe Marijuana Other
How many packs do/did you smoke per day? < 1 1 2 3 or more
Do you desire to quit? Yes No
How many alcoholic drinks do you consume in a normal week? None 1-2 3-4 5-6 >6
What type of alcohol do you generally consume? Beer Wine Liquor Other
Do you use any of the following drugs? Opioids Marijuana Cocaine Heroin Ecstasy Meth Other
How many days per week do you exercise? Never 1-2 3-4 Every Day
Are you interested in losing weight? Yes No
What is your marital status? Single Married Divorced Widowed
How many children do you have? What are their ages?
Who do you live with?
What do you do for a living?

REVIEW OF SYSTEMS

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? (**PLEASE CIRCLE**)

CONSTITUTIONAL	☐ N/A	Fever | Chills | Recent Weight Gain/Loss | Malaise/Fatigue |Weakness | Insomnia | Stress	
SKIN	☐ N/A	Rash | Itching | Skin Changes | Hair Changes | Nail Changes | Yellow Jaundice	
EARS, NOSE, MOUTH, THROAT	☐ N/A	Ear Aches| Hearing Loss | Ringing in Ears | Nose Bleeds | Sinus Problems | Frequent Colds | Dental Problems | Sore Throat Hoarseness | Wear Dentures	
EYES	☐ N/A	Wear Glasses | Wear Contacts | Vision Problems	
CARDIOVASCULAR	☐ N/A	Chest Pain | Irregular or Fast Heartbeat | Cold Extremities |Numbness | Weakness | Varicose Veins | Phlebitis | Leg Swelling |Pain When Walking	
RESPIRATORY	☐ N/A	Cough | Shortness of Breath | Spitting Up Blood | Asthma/Wheezing	
GASTROINTESTINAL	☐ N/A	Loss of Appetite | Nausea | Vomiting | Diarrhea | Constipation | Change in Bowel Habits Blood in Stool | Incontinence | Heartburn | Reflux	
GENITOURINARY	☐ N/A	Frequent Urination | Painful or Burning Urination | Incontinence Kidney Stones | Change in Force or Stream | Venereal Disease	
MUSCULOSKELETAL	☐ N/A	Joint Pain | Joint Swelling | Muscle Weakness | Back Pain	
ENDOCRINE	☐ N/A	Hormone Problem | Excessive Thirst or Urination | Heat Intolerance Cold Intolerance	
NEUROLOGICAL	☐ N/A	Headaches | Light Headed | Dizzy | Seizures | Paralysis | Change in Speech	
PSYCHIATRIC	☐ N/A	Memory Loss | Confusion | Nervousness | Anxiety | Depression	
HEME / LYMPHATIC	☐ N/A	Slow to Heal After Cuts| Anemia | Blood Transfusions | Bleeding/Bruising | Swollen Glands	
ALLERGY IMMUNOLOGIC	☐ N/A	Allergies | Hepatitis | HIV | AIDS | Chronic Infection	
BREAST	☐ N/A	Breast Pain | Breast Lump | Nipple Discharge | Bleeding| Skin Changes over Breasts	
MALES ONLY	☐ N/A	Testicle Pain | Prostate Problems	
WOMEN ONLY	☐ N/A	Last Menstrual Period: Age at First Period: Age at First Pregnancy: Ever had a breast biopsy?	# Pregnancies: # Full Term: # Miscarriages: Did you breastfeed?

Is there anything you are particularly worried about regarding today's visit?

Is there any other information you would like to share that is not covered above?