



Please fill out the Initial Patient Information Survey, and bring the following items.
[1] Completed Initial Patient Information Survey, [2] Insurance card.

First Name: _____

Last Name: _____

DOB: _____

Reason for Visit: _____

Referring physician: _____

Please provide the medications you currently take with dosage and frequency

PAST MEDICAL HISTORY

Please indicate any current/past medical conditions.

Circulatory System Conditions

- Abdominal Aortic Aneurysm
- Atrial Fibrillation
- Atrial Flutter
- Dysrhythmia (rhythm abnormalities)
- Carotid Artery Disease
- Congestive Heart Failure
- Heart Transplant
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)
- Mitral Valve Prolapse
- Myocardial Infarction (heart attack)

- Peripheral Vascular Disease (PAD)
- Varicose Veins

Endocrine & Metabolic Conditions

- Diabetes Type I
- Diabetes Type II
- Hypothyroidism (underactive thyroid)

Gastrointestinal Conditions

- GERD (Reflux Disease)
- Hiatal Hernia

Pulmonary Conditions

- Asthma
- COPD / Emphysema

Please list any other medical conditions you have not listed above.

PREVIOUS SURGERIES

Please provide a list of previous surgeries.

None. _____

SOCIAL HISTORY

Occupation

Current job: _____
 Retired
 Unemployed → Last job: _____

Personal Relations

Marital Status: Single / Married / Separated / Divorced / Widowed
 Spouse's Name: _____

Power of Attorney for Health care

Do you have a power of attorney for health care? NO / YES
 If YES, Name: _____ Relationship: _____

Caffeine Consumption

Type: None Coffee Tea Soda daily chocolates energy drinks
 Frequency: _____

Alcohol Consumption

Do you consume alcohol? _____
 If no, have you ever been a drinker: _____ Sober since: _____
 Type: Beer Hard Liquor Wine
 Frequency: _____

Tobacco Use

Do you now or have you ever been a cigarette/cigar smoker? Yes, No
 Years smoked: _____, Packs/Day: _____
 If you quit, when (Date)? _____
 Frequency Cigar Smoking: _____
 Frequency Chew Tobacco: _____

Recreational Drugs

Do you currently or have you used recreational drugs? NO / YES
 If YES, drugs Used/frequency: _____
 Date quit: _____

FAMILY MEDICAL HISTORY

Please fill out your family medical history below:

Family Member	Alive	Current Age OR Age at Death	Cause of Death	Medical Conditions
Mother	YES / NO			
Father	YES / NO			
Maternal Grandmother	YES / NO			
Maternal Grandfather	YES / NO			
Paternal Grandmother	YES / NO			
Paternal Grandfather	YES / NO			
Brothers	YES / NO			
Sisters	YES / NO			

ALLERGIES

Do you have any allergies to medications? If yes, please indicate name/s and reaction.

No known medication allergies

Medication	Reaction

HEART ARTERIES VEINS

REVIEW OF SYSTEMS

Please indicate yes or no to the following symptoms.

General	No	Yes
Recent weight loss		
Fever		
Recent weight gain		

Skin	No	Yes
Rashes		
Eruptions		
Loss of Hair		
Loss of Nails		

Eyes	No	Yes
Double vision		
Blurred vision		
Loss of vision		

Ears/Mouth/Throat	No	Yes
Hearing Loss		
Ringling in the Ear		
Nose Bleeds		
Nasal Congestion/Discharge		
Mouth Sores		
Hoarseness		
Difficulty swallowing		

Respiratory	No	Yes
Cough		
Bloody sputum/phlegm		
Wheezing		

Neurological	No	Yes
Headaches		
Head Trauma		
History of Convulsions		
Numbness or Tingling		
Gait Disturbance		
Slurred Speech		
Muscle Weakness		

Musculoskeletal	No	Yes
Recent Trauma		
Joint Swelling		
Joint Pain		
Muscle pain		
Pain in leg with walking		

Cardiovascular	No	Yes
Leg pain with walking		
Swollen veins		
Painful veins		
Leg skin ulcers		
Varicose veins		

Gastrointestinal	No	Yes
Appetite loss		
Nausea		
Rectal bleeding		
Abdominal Pain		
Diarrhea		
Constipation		
Tarry black stool		
Heart Burn		

Hematological	No	Yes
Easy bruising		
Bleeding problems		

Genitourinary	No	Yes
Pain with Urination		
Frequency		
Loss of Bladder Control		
Blood in Urine		
Frequent Urination at Night		