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| A picture containing table  Description automatically generated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Full Name: | | | |  | | | | | | | | | | Phone # | | | | |  | | | | | | | | | | | | |
| Height: | |  | | | | | | Weight: | | |  | | | Birth Date: | | | | | |  | | | | | | | | Age: | |  | |
| Reason for Today’s Visit: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Allergies: | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referring Physician: | | | | | | |  | | | | | | | | Preferred Pharmacy: | | | | | | | |  | | | | | | | | |
| **Previous Surgeries or Hospitalizations** | | | | | | | | | | | | | | | **Medications** | | | | | | | | | | | | | | | | |
| **Surgery/Hospitalization** | | | | | | | | | | | | **Date** | | | **Medication** | | | | | | | | | | **Dose** | | | | **Frequency** | | |
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| **Past Medical History (Check or mark with an “x” if you have/had the following):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Heart Disease | | | | | | | |  | Asthma | | | | | |  | Sleep Apnea | | | | | | | | |  | Diabetes | | | | |
|  | High Blood Pressure | | | | | | | |  | COPD | | | | | |  | Kidney Disease | | | | | | | | |  | Cancer | | | | |
|  | Mitral Valve Prolapse | | | | | | | |  | Tuberculosis | | | | | |  | Thyroid Disease | | | | | | | | |  | Depression/Anxiety | | | | |
|  | Stroke/TIA | | | | | | | |  | AIDS or HIV | | | | | |  | Arthritis | | | | | | | | |  | Anemia | | | | |
|  | Blood Clots | | | | | | | |  | Hepatitis | | | | | |  | Acid Reflux/Heartburn | | | | | | | | |  | Other (Notes Below) | | | | |
| **Review of Systems (Check or mark with an “x” if you have/had the following):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Weight Gain/Loss | | | | | | | |  | Swollen Feet/Ankles | | | | | |  | Anesthesia Problems | | | | | | | | |  | Rapid Heartbeat | | | | |
|  | Dry Eyes | | | | | | | |  | Joint or Muscle Pain | | | | | |  | Skin Rash | | | | | | | | |  | Seizures | | | | |
|  | Chronic Cough | | | | | | | |  | Swollen Lymph Nodes | | | | | |  | Easy Bleeding | | | | | | | | |  | Radiation Therapy | | | | |
|  | Chest Pain | | | | | | | |  | Cold Sore/Fever Blister | | | | | |  | Easy Bruising | | | | | | | | |  | Chemotherapy | | | | |
| **Family History (Check or mark with an “x” if you or a family member have/had the following):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Breast Cancer | | | | | | | |  | Diabetes | | | | | |  | Heart Disease | | | | | | | | |  | Depression | | | | |
|  | Melanoma | | | | | | | |  | Kidney Disease | | | | | |  | High Blood Pressure | | | | | | | | |  | Anxiety | | | | |
|  | Other Cancer | | | | | | | |  | Malignant Hyperthermia | | | | | |  | Stroke/TIA | | | | | | | | |  |  | | | | |
| **Social History:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you smoke or use tobacco products? | | | | | | | | | | | | |  | | Do you drink alcohol? | | | | | | | | |  | | | | | | | |
| If yes, type and amount per day? | | | | | | | | | | |  | | | | If yes, frequency? | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | Do you use “street drugs”? | | | | | | | | | | |  | | | | | |
| Do you vape? | | | | | |  | | | | | | | | | Description: | | | | | |  | | | | | | | | | | |
| **Other (please list any other health issue you may be having that is not listed above):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Women Only:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Last Mammogram? | | | | | | | | | |  | | | | | Bra Size? (if appointment is breast related) | | | | | | | | | | | | | | | |  |
| Signature: | | | | |  | | | | | | | | | | Date: | | |  | | | | | | | | | | | | | |