Patient Evaluation

Patient Name: _____ DOB: _____
Who referred you to our office? _____
Who is your primary care doctor? _____
Is there any other physician you would like to receive a report of your visit? If so, list below.
Name: _____ Location: _____
What is the problem that brings you here today? _____

Past Medical History
Do you have a history of any of the following?

High blood pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No

Prior Surgery: (List procedure and year)

_____

_____

_____

Review of Systems
Do you currently have any of the following?

Chest pain	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Leg pain	☐ Yes	☐ No
Visual disturbances	☐ Yes	☐ No
Poor appetite	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Nausea or vomiting	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Pain with urination	☐ Yes	☐ No
Skin problems	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Easy bleeding	☐ Yes	☐ No

Are you allergic to any medication(s)? ☐ Yes ☐ No

If yes, list medication(s)_____

Social History
Do you presently smoke cigarettes? ☐ Yes ☐ No

If yes, how many packs per day?_____ for how many years?_____

Did you smoke cigarettes in the past? ☐ Yes ☐ No

If yes, how many packs per day?____ for how many years?___ How long ago did you stop?___

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often?_____ How much?_____

Family History
Do any of your close relatives have…?

Heart disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Aneurysm	☐ Yes	☐ No

Patient Signature: _____ **Date:** _____ **Time:** _____

For office use:

Provider signature: _____ Date: _____ Time: _____
Provider signature: _____ Date: _____ Time: _____