HISTORY SHEET

Patient Name	DOB	MR#	Date of Exam

PLEASE COMPLETE (all responses will be kept confidential)

Referring Doctor (full name) +Telephone No.

Primary Doctor (full name) +Telephone No.

Height: **Weight:**

Cardiologist (full name) + Telephone No.

MEDICAL HISTORY: **Please List below (or circle NONE if applicable):

HEALTH PROBLEMS: NONE

1. 2. 3. 4. Additional:

PREVIOUS SURGERY: NONE

1. 2. 3. 4. Additional:

FAMILY HISTORY: (Please circle if a family member has any of the following diseases):

HEART DIABETES EYE Additional:

SOCIAL HISTORY:

Do you smoke tobacco? NO YES If yes, how much? _____

Do you drink alcohol? NO YES If yes, how much? _____

Are you currently working? NO YES If yes, what type of job? _____

Do you currently have any problems of the following areas? If YES, circle, and provide additional information as needed:	**NO YES**	**DETAILS**
EYES (poor vision, pain, tearing, redness, etc)	NO / YES	
GENERAL/ CONSTITUTIONAL (fever, weight loss, weight gain, unusually tired, etc)	NO / YES	
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earaches, sinus,dry mouth, etc)	NO / YES	
CARDIOVASCULAR (high BP, racing pulse, etc)	NO / YES	
RESPIRATORY (congestion, wheezing, short of breath, etc)	NO / YES	
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc)	NO / YES	
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, etc)	NO / YES	
FEMALES (are you pregnant? Nursing)	NO / YES	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc)	NO / YES	
SKIN (pimples, warts, growths, rash, etc)	NO / YES	
NEUROLOGIC (numbness, headache, seizures, weakness, etc)	NO / YES	
PSYCHIATRIC (anxiety, depression, insomnia, etc)	NO / YES	
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc)	NO / YES	
BLOOD/LYMPH (bleeding, anemia, etc)	NO / YES	
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc)	NO / YES	