Using Adobe Acrobat Reader 8.0 or later

Patient History

Please answer every question.

STAFF: Responses in boxes
and handwritten items must
be entered MANUALLY.

PLEAS PRINT PATENTS RIST NAME					PLEASE	PRINT P	ATIENT	'S LAST	NAME							j	
Please use a #2 pencil. Ill in the complete oval as shown Primary Care Physician: What is the reason for your visit today? Please indicate if You have a history of the following. Mark all that apply. If none, mark, "NO MEDICAL HISTORY." PAST CURRENT Angina (Chest Pain) Aortic Aneurysm Bleeding Tendencies Bleod Clot(s) Blood Cl	N	1arking I	nstructions	100													
Today's date: / / Referring Physician: Referring Ph		_			PLEASE	PRINT P	ATIENT	'S FIRST	NAME		P	ATIENT	'S DATE	OF BI	RTH		
Today's date:/			s shown											ÌΓ			
Primary Care Physician: What is the reason for your visit today? Please indicate if YOU have a history of the following. Mark all that apply. If none, mark, "NO MEDICAL HISTORY." PAST CURRENT Angina (chest Paln) Heart Valve Problem High Blood Pressure Bleeding Tendencies High Cholesterol Blood Clot(s) HIV Positive Cancer Hyperthyroid Cardiomyopathy Hyperthyroid Cirrhosis of Liver Kidney Disease (chronic) COPD Lupus Coronary Artery Disease Diabetes (Type 1 Adwille Onset) Peripheral Artery Disease (pap) Diabetes (Type 1 Adwille Onset) Peripheral Artery Disease (pap) Diabetes (Type 1 Adwille Onset) Peripheral Artery Disease (pap) Emphysema Peripheral Artery Disease (pap) Billed (Type 2 Adult Onset) Peripheral Artery												/onth	Dav		Y	'ear	
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Please indicate if YOU have a history of the following, Mark all that apply. If none, mark, "NO MEDICAL HISTORY." PAST CURRENT Angina (Chest Pain) Aortic Aneurysm Bleeding Tendencies Bleeding Tendencies Blood Clot(s) Blood Clot(s) Cancer Hyperthyroid Cardiomyopathy Cirrhosis of Liver Corpo Coronary Artery Disease Diabetes (Type 1 Juvenile Onset) Diabetes (Type 1 Juvenile Onset) Emphysema Bilepsy Bileps	Primary Ca	are Physicia	n:				Refer	ring P	hysicia	n:							
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Other Disease, Cancer or Significant Medical Illness (please specify): DIAGNOSTIC TESTS			Heart Failure							\supset	Tra	nsien	t Ische	mic /	4ttack	(TIA)	
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Please indicate when you last had each of the applicable tests: Angiogram: Abdominal Aorta Angiogram: Coronary Arteries Angiogram: Neck Arteries Angiogram: Neck Arteries Fixed Fixed										O MED	DICAL	HISTC	RY				
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Angiogram: Abdominal Aorta Angiogram: Coronary Arteries Angiogram: Legs / Arms Angiogram: Neck Arteries Colonoscopy EKG Mammogram Pap / Pelvic Exam Rectal Exam Stress test	Please i	indicate wh	en you last had licable tests:	Wa .	1 year or !	Lyears ago	veats ago	5 ye	ars ago Vears	ago years	8 years a	go years at	JO' YEARS	,40		e the r	esults:
Angiogram: Legs / Arms						49	19		$\frac{2}{2}$		\exists				$\exists \subseteq$		2
Angiogram: Neck Arteries	А						10	0					2				2
Colonoscopy					\exists	49	19		$\frac{2}{2}$		$\exists \vdash$	$\exists \subseteq$	2		$\exists \subseteq$	219	2
EKG O		Angiogra		9		$\frac{1}{2}$	10		$\frac{9}{2}$	\exists			4		$\exists \subseteq$	4	4
Mammogram 0					\exists	$\frac{1}{2}$	10		$\frac{2}{2}$	\exists	\exists	$\exists \vdash$			4	4	4
Pap / Pelvic Exam O				9		$\frac{1}{2}$	10		\bigcirc	\Rightarrow			2		$\exists \subseteq$	215	4
Rectal Exam O O O O O O O O O O O O O O O O O O O		_				$\frac{1}{2}$	19		$\frac{2}{2}$		\exists				$\exists \subseteq$	215	2
Stress test OOOOOOOOOOOO		P	•	99			10		$\frac{2}{2}$		\exists	$\exists \vdash$	2			219	4
					\exists	$\frac{1}{2}$	10		$\frac{2}{2}$		\exists	$\exists \vdash$			4	4	4
	*************	on Chaffe Al				70			$\frac{\mathcal{O}}{\mathcal{O}}$							7	2

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Patient History

Please answer every question.

STAFF: Responses in boxes
and handwritten items must
be entered MANUALLY .

lave you experienced menopausal stave you gone through menopause? lave you had any pregnancy complication. SURGICAL HISTORY I HAVE HAD NO SURGERIES Appendectomy Cardiac Ablation Carotid Artery (Neck) Stent Carotid Artery (Neck) Surgery Colon Surgery	cations? Plea Ga				yes yes		no O	maybe maybe	
URGICAL HISTORY I HAVE HAD NO SURGERIES Appendectomy Cardiac Ablation Carotid Artery (Neck) Stent Carotid Artery (Neck) Surgery	Plea G	se mark al			yes C	\supset	no 🔘		
Appendectomy Cardiac Ablation Carotid Artery (Neck) Stent Carotid Artery (Neck) Surgery	◯ Ga	se mark a							
Appendectomy Cardiac Ablation Carotid Artery (Neck) Stent Carotid Artery (Neck) Surgery			ll surgeries y	ou have h	ad:				
Cardiac Ablation Carotid Artery (Neck) Stent Carotid Artery (Neck) Surgery	○ H ₄	allbladder	Removal		C Leg	g Bypass Su	irgery		
Carotid Artery (Neck) Stent Carotid Artery (Neck) Surgery	<u> </u>	eart Balloc	n / Stent		Lower Back Surgery				
Carotid Artery (Neck) Surgery		eart Bypas			Pacemaker				
		eart Trans			Prostate Surgery				
Colon Surgery		eart Valve			Upper Back Surgery				
Defibrillator		sterecton	•			ricose Vein	Surgery		
Delibrillator	C Le	g Balloon	/ Stent		IVI	astectomy left	right (both	
ther surgery, diagnostic procedure o				and to (pieu	se spee,,.				
AMILY MEDICAL HISTORY	1								
Family History UNKNOV	WN		DOPTED		SIGNIFICA	ANT Family	History		
Please indicate which family member(s) have had these illnesses:	Father	Mother		Grandfather Mother's side			Brother	Sister	
Anemia									
Asthma									
Bleeding Problems								0	
Cancer (please specify type below)									
Coronary Artery Disease (< age 50)									
Coronary Artery Disease (< age 50) Coronary Artery Disease (> age 50)			0	0	0	0	0	0	
	0	0	0	0	0	0	0 0 0	0 0 0	
Coronary Artery Disease (> age 50) Diabetes (Type 2 Adult Onset) Emphysema	0	0 0	0	0	0 0 0	0000	0000		
Coronary Artery Disease (> age 50) Diabetes (Type 2 Adult Onset) Emphysema Epilepsy					0				
Coronary Artery Disease (> age 50) Diabetes (Type 2 Adult Onset) Emphysema Epilepsy Heart Attack (MI – Acute)			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0					
Coronary Artery Disease (> age 50) Diabetes (Type 2 Adult Onset) Emphysema Epilepsy Heart Attack (MI – Acute) Heart Disease			000000000000000000000000000000000000000			0000000		000000000000000000000000000000000000000	
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Coronary Artery Disease (> age 50) Diabetes (Type 2 Adult Onset) Emphysema Epilepsy Heart Attack (MI – Acute) Heart Disease Heart Failure Heart Rhythm Problem		000000000000000000000000000000000000000	000000000000000000000000000000000000000			000000000000000000000000000000000000000			
Coronary Artery Disease (> age 50) Diabetes (Type 2 Adult Onset) Emphysema Epilepsy Heart Attack (MI – Acute) Heart Disease Heart Failure Heart Rhythm Problem High Blood Pressure		000000000000000000000000000000000000000				000000000000000000000000000000000000000			
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Coronary Artery Disease (> age 50) Diabetes (Type 2 Adult Onset) Emphysema Epilepsy Heart Attack (MI – Acute) Heart Disease Heart Failure Heart Rhythm Problem High Blood Pressure						000000000000000000000000000000000000000			

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Please answer every question.



SOCIAL HISTORY					
ALCOHOL USE					
Do you now, or have you ever used a	alcohol?			recovering alcoho	
never drank alco	hol 🔘			ped drinking alcol	
	yes 🔘	If you no longe	r drink alcohol	, when did you sto	p:
yes, in moderation (< 2 per o					
How many cans / bottles of beer per		1 - 7 🔾	8 - 14 🔵	15 - 21 🔾	22 + 🔾
How many glasses of wine per week		1 - 7 🔾	8 - 14 🔵	15 - 21 🔘	22 + 🔾
How many drinks of liquor per week	? 0 🔾	1 - 7 🔾	8 - 14 🔵	15 - 21 🔾	22 + 🔾
CAFFEINE USE					
•	do not use caffeine		occasionally	· · · · · · · · · · · · · · · · · · ·	egularly O
How many cups of coffee per day?	0 0	1 0	2 🔾	3 🔾	4+ 🔾
How many cups / glasses of tea per o		1 0	2 🔾	3 🔾	4+ 0
How many soft drinks per day?	0 🔾	1 🔾	2 🔾	3 🔾	4+
DRUG USE Do you use illicit drugs?			105	no in i	the past
	mnhotaminos (res O		the past
willen type(s).	mphetamines O	cocai hero		LSD / hallud	arijuana
EDUCATION Mark highest level:	Dai Diturates	grades 1			e school
LUCCATION Wark Highest level.		grades 1 -			te (13+)
	NONE _	_	ED O	postgradua	
EMPLOYMENT:	NONE	working part tir		currently on d	
working full ti	me not c	currently employ		currently on c	retired O
ETHNICITY: Hispanic or Lat		anic or Latino		ined O	nknown
RACE:	110 1100 11100	ariic or Eatino	ucon	inca u	White 🔾
American Indian or Alaska Nat	ive 🔘	Black o	r African Amer	ican 🔾 u	nknown 🔾
		Hawaiian or Ot			declined 🔵
LANGUAGE PREFERENCE:					
English 🔾	Viet	namese 🔘		other (please	e specify):
Spanish 🔘		Korean 🔘			
LEVEL OF PHYSICAL ACTIVITY:			exerc	cise inhibited by co	ondition 🔘
	sedentary 🤇			exercise r	
	heavy labor on job	physi		erance recently de	
LIVING ARRANGEMENTS:			,	with or caring for	
	independent			with grandp	
	independently with				arent(s)
	residential ins	stitution 🔾		with room	mate(s)
MARITAL STATUS:		ما المحسمة الم			
married O	separated	divorced <	wido		single O
DIET Mark any specific nutritional plan				vegetarian o	_
high fiber Olow cholesterol	low sug	fat O		other (please	e specify):
TOBACCO USE	iow sug	gai			
Smoking status:	current smoker (ev	erv day)		never	smoked O
Smoking status.	current smoker (son		smoke	r, current status u	
		smoker O	Sinoke	unknown if ever	
Do you wish to stop smoking?				yes 🔾	no O
Packs per day (now or in the past):	<1 🔘	1 🔘	1-1½	1 ½ - 2	> 2 🔘
Years smoked (now or in the past):		less than 5		15 20 25 3	0 35 40+
Do you use other tobacco products?		ars 🔵 pi	pe 🔵	chewing tobacco	o / snuff 🔘
If you smoke cigars or a pipe, how m	= =				
	occasionally O	1 🔾	2 - 7 🔵	8 - 14 🔾	15+ 🔾
If you use chewing tobacco or snuff,	=				_
	occasionally O	<1 🔾	1 🔾	1 - 2 🔾	> 2 🔾
Are you exposed to passive (second	hand) smoke?	yes, outdo	ors only 🔾	yes 🔾	no 🔾



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ALLERGIES Plea	se mark all allergie	-		de your reactions. (e.g., hive	s, welts, ra	ish, itching, na	ausea, etc.)
		○ I HAVE	NO KI	NOWN ALLERGIES			
Substance:	Reaction:		Su	bstance:		Reaction:	
Aspirin				Dairy			
Dyes for X-Ray Tests	S			Eggs			
Penicillin				⊃ Latex			
Sulfa				Shellfish			
Medication Allergy				Food / Environmental Al	lergy		
(please specify):				(please specify):	0,		
	1				-		
				dications, vitamins and supplemen			
ame of Medication	Dosage	Frequency]	Name of Medication		Dosage	Frequency
			-				
]				
PHARMACY							
hat is the primary pharm	acy that you use?	Name:		Locati	on:		
o you use a mail order ph	armacy?	Name:		Locati	on:		
ADULT IMMUNIZAT	TIONS	Please li	ist all	immunizations you have ha	nd:		
				, , , , , , , , , , , , , , , , , , , ,			
ame of Immunization	Date]	Name of Immunization	Date		
Flu							
				Other (please specify):			
Hepatitis B			-				
Pneumonia							
Tetanus							
MMR							

Zoster