Patient Name: _____

Date of Birth: _____

CURRENT MEDICAL PROBLEM

What problem brought you here?

What symptoms are you having?

Date of onset?

Has your appetite changed in the last six months?
☐ Increased ☐ Decreased

Has your weight changed in the last six months?
☐Increased lbs. _____ ☐Decreased lbs._____

Has your overall energy level changed?
☐ Increased ☐ Decreased ☐ Stayed the same

PAST MEDICAL HISTORY

☐Nothing reported
☐ Anemia
☐ Aneurysm
☐ Arthritis and/or Gout
☐ Atrial Fibrillation
☐ Bleeding problems
☐ CAD
☐ COPD
☐ Cancer (type _____)
☐ Cardiomyopathy
☐ Diabetes
☐ Kidney stones/disease
☐ Liver problems
☐ CVA (stroke)
☐ CHF (congestive heart failure)
☐ Heart failure
☐ Heart flutter or murmur
☐ Heart Disease
☐ High blood pressure
☐ High cholesterol
☐ Pacemaker/Defibrillator
☐ Phlebitis, Blood clots
☐ PVD
☐ Rheumatic fever
☐ Stents
☐ Stroke
☐ Thyroid disease (hyper or hypo)
☐ Valve replacement

SURGERIES/HOSPITALIZATIONS

Procedure	Date	Surgeon/Location

MEDICATIONS

Medicine name	Dose

SOCIAL HISTORY

Are you a smoker?

☐Yes (Since what age? _____ How many cigarettes per day? _____)
☐ No ☐Formerly (when did you stop? _____)
☐Chewing tobacco
☐Illicit Drugs _____

Alcohol intake

How many drinks per week?

Exercise level

How many times per week?

Caffeine Intake

How many servings per day?

Diet

☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten free
☐ Specific carbohydrate ☐ Mediterranean
☐ Other _____

FAMILY HISTORY
Mother:
☐Heart failure ☐Sudden unexplained death
☐CAD ☐ High blood pressure
☐ Heart disease/ flutter/ murmur
☐ Cancer (type ________________________________)
Age:
Father:
☐Heart failure ☐Sudden unexplained death
☐CAD ☐ High blood pressure
☐ Heart disease/ flutter/ murmur
☐ Cancer (type ________________________________)
Age:
Other:
Relationship ___________________________________
☐Heart failure ☐Sudden unexplained death
☐CAD ☐ High blood pressure
☐ Heart disease/ flutter/ murmur
☐ Cancer (type ________________________________)
Age:

ALLERGIES		
Drug/Allergen	Reaction	Onset date

CARE TEAM			
Type of Provider		Type of Provider	
☐ Primary Care Provider ☐ Referring Provider ☐ Other		☐ Primary Care Provider ☐ Referring Provider ☐ Other	
Specialty		Specialty	
Name		Name	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	
Fax		Fax	
Type of Provider		Type of Provider	
☐ Primary Care Provider ☐ Referring Provider ☐ Other		☐ Primary Care Provider ☐ Referring Provider ☐ Other	
Specialty		Specialty	
Name		Name	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	
Fax		Fax	
Type of Provider		Type of Provider	
☐ Primary Care Provider ☐ Referring Provider ☐ Other		☐ Primary Care Provider ☐ Referring Provider ☐ Other	
Specialty		Specialty	
Name		Name	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	
Fax		Fax	