



Name: _____ Date of Birth: _____

Reason for your visit today: _____

Which physician requesting consult? _____

Primary care physician? _____

PAST MEDICAL HISTORY Please list your past/present medical problems:

SURGICAL HISTORY: Please list all past surgeries:

Procedure	Date

Procedure	Date

CARDIAC TESTING: Please list all previous cardiac testing you may have had:

Test Name	Date

Test Name	Date

ALLERGIES:

Drug Name	Reaction

Drug Name	Reaction

Date of your Last Flu Shot: _____ Date of your last Pneumonia Vaccine: _____

Vitals: (for office use only)

Height: _____ Weight: _____ Pulse: _____ SpO2: _____ BP: _____ Temp: _____

Name: _____ DOB: _____

REVIEW OF SYSTEMS

Please check if you are currently having or have had a history of the following:

CONSTITUTIONAL

- ___ Excess Weight Loss
- ___ Excess Weight Gain
- ___ Fever
- ___ Exercise Intolerance
- ___ Night Sweats

ENT and EYES

- ___ Sore Throat
- ___ Snoring
- ___ Sinus Problems
- ___ Hearing Loss
- ___ Ear Pain
- ___ Nose Bleeding
- ___ Vision Changes
- ___ Dry Eyes

CARDIOVASCULAR

- ___ Chest Pain
- ___ Arm Pain w/exertion
- ___ Shortness of breath w/walking
- ___ Shortness of breath w/lying down
- ___ Palpitations
- ___ Heart Murmur

RESPIRATORY

- ___ Cough
- ___ Wheezing
- ___ Shortness of Breath
- ___ Coughing up Blood

GASTROINTESTINAL

- ___ Change in Appetite
- ___ Heartburn
- ___ Nausea
- ___ Vomiting
- ___ Constipation
- ___ Diarrhea
- ___ Blood in Stool
- ___ Abdominal Pain
- ___ Ulcers

GENITOURINARY

- ___ Incontinence
- ___ Blood in Urine
- ___ Frequency
- ___ Difficulty Urinating

MUSCULOSKELETAL

- ___ Swelling in Extremities
- ___ Back Pain
- ___ Joint Pain
- ___ Muscle Weakness
- ___ Muscle Aches

SKIN

- ___ Rashes
- ___ Abnormal Moles
- ___ Itching
- ___ Dry Skin
- ___ Jaundice

NEUROLOGICAL

- ___ Fainting
- ___ Muscle Weakness
- ___ Numbness
- ___ Headaches
- ___ Stroke
- ___ Dizziness
- ___ Seizures

PSYCHIATRIC

- ___ Depression
- ___ Sleep Disturbance
- ___ Feel Unsafe
- ___ Alcohol Abuse
- ___ Anxiety

ENDOCRINE

- ___ Fatigue

HEMATOLOGIC

- ___ Bruise Easily
- ___ Swollen Glands
- ___ History of Blood Clots

ALLERGIC

- ___ Runny Nose
- ___ Sinus Pressure
- ___ Itching
- ___ Hives
- ___ Frequent Sneezing

OTHER: (please list)

- ___ Steroid Use
- ___ Asthma
- ___ Heart Attack
- ___ High Blood Pressure
- ___ Thyroid Disease
- ___ Anemia
