

CLINICAL INFORMATION

Patient Name: _____ **DOB:** _____

MEDICAL HISTORY

- | | | | |
|--|---------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> COPD | <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Triglycerides | <input type="checkbox"/> Allergies | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer: _____ | |
| <input type="checkbox"/> Low Thyroid | <input type="checkbox"/> Anxiety | _____ | |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Insomnia | _____ | |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Chronic Pain | Other Medical Hx: _____ | |
| <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Arthritis | _____ | |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Gout | _____ | |

SURGICAL HISTORY

- | | | | |
|---------------------------------------|-------------------------------|--------------------------------------|------------------------|
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> Hip | <input type="checkbox"/> Hernia | Other Surgeries: _____ |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Knee | <input type="checkbox"/> Cataracts | _____ |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Neck | <input type="checkbox"/> Skin Cancer | _____ |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Back | <input type="checkbox"/> Prostate | _____ |

FAMILY HEALTH HISTORY

- Father: Alive Deceased Conditions: _____
- Mother: Alive Deceased Conditions: _____
- Brothers: # Alive _____ # Deceased _____ Conditions: _____
- Sisters: # Alive _____ # Deceased _____ Conditions: _____
- Children: # Alive _____ # Deceased _____ Conditions: _____

SOCIAL / LIFESTYLE HISTORY

- Single Married Divorced Widowed Separated Remarried
- Alcohol: None Rare Some Days Most Days Excessive
- Tobacco: Never Past Current (Details: _____)
- Illegal Drugs: Never Past Current (Details: _____)
- Who lives at home with you? _____ Pets: _____
- Employment: Employed Retired (Type of work: _____)
- Nutrition: Poor Fair Good Excellent Special Diet: _____
- Exercise: None Occas Often Regular (Type: _____)
- Transportation: Drive myself Others drive Don't leave the house
- Ambulation Aides: None Cane Walker Wheelchair Lift Chair Ramp
 Chair Lift Hoyer Lift Other: _____
- Equipment/Devices: Hearing Aids Dentures CPAP Oxygen Suction
 Foley G-Tube / PEG Tube Bedside Commode Shower Chair Hospital Bed
 Other: _____

