



**Patient Profile:** Briefly describe your occupation (housewife, actively working, etc.) If you are working describe what type of work you do. If you are retired, describe what type of work you primarily did.

**Active Problems:** List any condition for which you presently are receiving medical attention and the treating physician.

Condition	Physician

**Reason for visit:** List problems for which you are here to see about.

Symptoms (such as chest pain, shortness of breath, etc.)	Location of symptom, duration, how often and what alleviates this?

**Review of systems:** Are you allergic to any medication?  No  Yes  
If yes, list medication and the type of reaction.

Medication	Reaction

Are you bothered with (please describe):

Shortness of breath, either walking, at rest, or awaking you at night?  No  Yes

Swelling in the legs?  No  Yes

Chest, neck, or arm discomfort (pressure, fullness, burning, heaviness, sharp or dull pain)?  No  Yes

Excessive cough?  No  Yes

Palpitations or heart fluttering?  No  Yes

Dizziness or problems with your head?  No  Yes



**Family History:** List each family member (parents, grandparents, brothers, sisters, aunts, uncles, cousins) and indicate if they have had any of the following diseases: 1) Heart disease, including heart attacks, dropsy, heart failure and palpitations: 2) High blood pressure: 3) Diabetes mellitus; 4) Strokes; 5) Cancer

	Problem(s)	If deceased, cause of death	age at death
Mother			
Father			
Brothers			
Sisters			
Grandparents			
Aunts			
Uncles			
& Cousins			

**Social History:**

1. Do you smoke now or have you in the past smoked or used tobacco?  No  Yes  
 If currently smoking or using: \_\_\_\_Packs per day for \_\_\_\_ years.  
 If quit, how long ago did you quit\_\_\_\_\_
  
2. Are you exposed to second hand smoke?  No  Yes
  
3. Have you ever had a drug dependency problem?  No  Yes
  
4. Do you exercise regularly?  No  Yes  
 If yes, how often? \_\_\_\_\_ days per week
  
5. Do you drink caffeinated beverages or beverages with NutraSweet?  No  Yes  
 If yes, how much? \_\_\_\_\_  Caffeine  NutraSweet
  
6. Do you drink alcoholic beverages?  No  Yes  
 If yes, how much?\_\_\_\_\_