Who referred you to our practice or how did you hear about us?_____

Reason for visit:

_____

Preferred Language: ☐English ☐Spanish ☐Other_____ **Ethnicity:** ☐Hispanic/Latino ☐Not Hispanic/Latino
Race: ☐White ☐African American ☐Asian ☐American Indian ☐Other_____ ☐Declined **Gender:** ☐Male ☐Female

Flu vaccination: Date received_____ Declined to receive: ☐
Pneumonia vaccination if >65 years old: Date received_____ Declined to receive: ☐
COVID vaccination Date of 1st dose: _____ Date of 2nd dose: _____ Date of Booster: _____Declined to receive: ☐
☐ Moderna ☐ Pfizer ☐Johnson & Johnson

Medications (complete list required) **Dose** **Frequency**
You can ask your pharmacist to print your medication list and bring it with you instead of filling out this part
If none please check here_____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to Medication, Adhesives, Contrast or Metals, etc **If none please check here:** _____
Reaction **Description**

_____
_____
_____

Have you ever had a reaction to either of the following? Any metal, or been diagnosed with a metal allergy (ex. Nickle)?
☐ Contrast Dye ☐ Metals, such as nickle ☐ None
If yes, what was the reaction and when did you have it?_____
_____
If yes, have you seen an allergist, and if so, whom? _____

Physician Care Team:

☐ Hematologist _____ ☐ Cardiologist _____ ☐ Nephrologist _____

Past Surgical History

☐ None	☐ Cataracts	☐ Tonsillectomy	☐ Adenoidectomy	☐ Thyroidectomy
☐ Coronary Bypass	☐ Cardiac Stents	☐ Pacemaker	☐ Heart Valve	☐ Gall Bladder
☐ Appendectomy	☐ Bowel/Stomach (including bariatric): _____			☐ C-Section
☐ Hysterectomy	☐ Hernia:_____	☐ Spinal Surgery:_____		☐ Tubal Ligation
☐ Bladder Surgery	☐ Prostate	☐ Leg artery stent	☐ Leg bypass	
☐ Carotid artery stent	☐ Orthopedic/joints_____			
☐ Other_____				

Past Medical History - **Do you have any of the following conditions? If none, please check here** _____

Endocrine: ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐Hypothyroid ☐ Hyperthyroid

Cardiac:
☐High Cholesterol ☐High Blood Pressure ☐ Angina
☐MI/heart attacks ☐Congestive Heart Failure ☐ Valve Disorder _____
☐Coronary Disease ☐ Atrial Fibrillation ☐ Carotid Artery Stenosis
- ☐Heart Stenting -☐Pacemaker -☐ Endarterectomy
- ☐Heart Bypass -☐ Stenting

Hematologic: ☐Anemia ☐DVT (leg clots): left / right ☐Pulmonary Emboli (lung clots)

Skin: ☐Chronic Wounds ☐Varicose veins

Gastrointestinal: ☐Heart Burn, Reflux ☐Stomach Ulcers

Respiratory: ☐COPD/Emphysema ☐Sleep apnea ☐Asthma

Psychiatric: ☐Depression ☐Bipolar Disorder ☐Anxiety

Neurological: ☐Stroke ☐Headaches ☐Seizures

Musculoskeletal: ☐Arthritis ☐Osteoporosis ☐Back pain

Kidney: ☐Kidney Disease -Stage _____ ☐Kidney failure on dialysis - ☐ Hemodialysis - ☐ Peritoneal dialysis Nephrologist:_____

Bloodborne Pathogens: ☐ HIV ☐ Hepatitis

Cancer: Type: _____
Treatment: _____

Family History - **Do/did your parents and siblings have/had any of the following conditions?**
☐ None ☐ Unknown
☐ Diabetes ☐High Blood Pressure ☐ Heart Disease ☐ Blood Clots: If so, please check one ☐ DVT or ☐ STP
☐ Varicose Veins ☐ Stroke ☐ High Cholesterol
☐Cancer:_____ ☐ Other: _____

Social History
Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Widowed
Tobacco use: ☐ Never smoked ☐ Chews Tobacco
☐ Current smoker Packs per day: _____ Number of years smoking:_____
☐ Former smoker Year when quit: _____
Alcohol use: ☐ Never ☐ Occasionally ☐ Daily ☐ Rarely ☐ Former
Drug use: _____

Continued on next page...

Check all that pertain to you:

Constitutional Symptoms
- ☐ Good general health lately
- ☐ Recent weight: gain / loss
- ☐ Fever
- ☐ Fatigue

Eyes/Ears/Nose/Mouth/Throat
- ☐ Eye disease or injury
- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Chronic sinus problems or rhinitis
- ☐ Sore throat or voice change
- ☐ Swollen glands in neck

Cardiovascular
- ☐ Heart trouble
- ☐ Chest pains or angina pectoris
- ☐ Palpitations
- ☐ Shortness of breath w/ walking or lying flat
- ☐ Swelling of feet, ankles, or legs

Respiratory
- ☐ Chronic or frequent coughs
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing

Genitourinary
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Female - date of last pap smear____
- ☐ Female - # of pregnancies ____

Endocrine
- ☐ Glandular/hormone problems
- ☐ Excessive thirst or urination
- ☐ Heat Intolerance

Musculoskeletal
- ☐ Joint stiffness or swelling
- ☐ Weakness of muscles or joints
- ☐ Muscle pain or cramps
- ☐ Back pain
- ☐ Joint pain
- ☐ Cold Extremities
- ☐ Difficulty in walking

Integumentary (skin, breast)
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Varicose veins

Gastrointestinal
- ☐ Loss of appetite ☐ Abdominal Pain
- ☐ Frequent diarrhea
- ☐ Constipation

Psychiatric
- ☐ Memory loss or confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

Hematologic/Lymphatic
- ☐ Enlarged glands
- ☐ Anemia
- ☐ Slow to heal after cuts
- ☐ Phlebitis
- ☐ Past transfusion

Allergic/Immunologic
- ☐ Iodine
- ☐ Contrast Dye
- ☐ Novocain or other anesthetics
- ☐ Penicillin or other antibiotics

Neurological
- ☐ Frequent or recurring headaches
- ☐ Light headed or dizzy
- ☐ Convulsions or seizures
- ☐ Head injury
- ☐ Tremors
- ☐ Paralysis

Name: Test Test Date: 11/06/24 Date of Birth: 00/00/0000

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient,
Parent or Guardian _____ Today's Date:_____

Provider Signature:_____ Date:_____

Health Care Proxy

I, (your name here) , hereby appoint:

_____

(**Name of person you elect to be your health care proxy**, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

_____

(Appointee's name, home address and telephone number)
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):

_____

Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary):

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

_____

Your Name:
Your Signature _____ Date _____

Your Address:

Optional: Organ and/or Tissue Donation
I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)
☐ Any needed organs and/or tissues ☐ The following organs and/or tissues_____
☐ Limitations_____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature_____ Date_____

Statement by Witnesses (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)
I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date_____ Date_____
Name of Witness 1 _____ Name of Witness 2_____
Signature _____ Signature _____