

esse HEALTH	Patient Name:	
We Want You Well.	Date:	
Main Reason for Your Vi	t:	
Medication List (Includin	over the counter medications):	
Allergy to Medications:		

PAST MEDICAL HISTORY

DIABETES	YES	NO	EMPHYSEMA/COPD	YES	NO
HIGH BLOOD PRESSURE	YES	NO	PNEUMONIA	YES	NO
STROKES	YES	NO	DEPRESSION/BIPOLAR	YES	NO
HEART DISEASE/HEART ATTACK	YES	NO	MENTAL ILLNESS	YES	NO
KIDNEY STONES	YES	NO	DEMENTIA/ALZHEIMER'S ETC.	YES	NO
THYROID DISEASE	YES	NO	ULCER	YES	NO
SEIZURES	YES	NO	LIVER DISEASE	YES	NO
BLEEDING DISORDER	YES	NO	HIGH CHOLESTEROL	YES	NO
SEXUALLY TRANSMITTED DISEASE	YES	NO	IRRITABLE BOWEL SYNDROME	YES	NO
TUBERCULOSIS	YES	NO	GLAUCOMA (narrow angle) (wide angle)	YES	NO
RHEUMATIC FEVER	YES	NO	DIABETES	YES	NO
ASTHMA	YES	NO	CANCER	YES	NO
ANXIETY	YES	NO	~CANCER TYPE	YES	NO

PAST SURGICAL HISTORY

Heart Bypass		Appendectomy	Hysterectomy Abdominal Vaginal	
Inguinal Hernia: Left	Right	Both	Gallbladder: Open Laparoscopic	Ovaries Removed: Left Right Both
Umbilical Herni	a Repair		Vasectomy	
Joint Replacement(s):				

FAMILY HISTORY	: (Please circle Me	dical Problems that	run in your family)	NONE	PROSTATE CANCER
BLADDER CANCER	KIDNEY CANCER	KIDNEY STONES	HEART DISEASE	DIABETES	STROKES
OTHER:					

	Y							
SE OF TOBACCO: Never] Quit/Year:		Yes	, Packs/	Day:	Other:		
ECREATIONAL DRUG USE: ☐Ne	ver	uit ∐Yes, [:]	Type & Fr	equency	:			
ARITAL STATUS: Single M								
SE OF ALCOHOL: Never Q	uit <u></u> Rare	elyOcca	sionally	∐Mode	rate	Heavy Amount:		
CCUPATION: ☐Full-time ☐Pa	rt-time F	Retired D	isabled 、	Job Desc	cription: _			
EVIEW OF SYSTEMS								
FEVER/CHILLS/NIGHT SWEATS	YES	NO	HEAF	RTBURN/	DIFFICUL	TY SWALLOWING	YES	N
DIZZY LIGHTHEADED	YES	NO	ABDO	DMINAL [DISCOMF	ORT	YES	N
WEIGHT CHANGE	YES	NO	NAUS	SEA/VON	IITING		YES	NO
ALLERGIES/COLD SYMPTOMS	YES	NO	BLOG	DDY/BLA	CK STOO	LS	YES	N
VISUAL PROBLEMS	YES	NO	RASH	HES			YES	NO
HEADACHES	YES	NO	HEAF	RTBURN/	DIFFICUL	TY SWALLOWING	YES	NC
NECK/BACK PAIN	YES	NO	URIN	ARY PRO	OBLEMS		YES	NO
COUGH	YES	NO	VAGI	NAL/PEN	IILE DISC	HARGE	YES	N
SHORTNESS OF BREATH	YES	NO	INCR	EASED 1	THIRST/U	RINATION	YES	NO
CHEST DISCOMFORT	YES	NO	DEPF	RESSION	/ANXIETY	1	YES	NO
CHEST DISCOMFORT PALPITATIONS	YES YES	NO NO		RESSION MNIA	/ANXIET\	<i>(</i>	YES	
PALPITATIONS IISTORY OF PRESENT IL Location of the problem:	YES	NO Please circle	inso	MNIA answer t	he follov		YES	
PALPITATIONS	YES	NO Please circle	inso	MNIA answer t	he follov	ving questions)	YES	
PALPITATIONS IISTORY OF PRESENT IL Location of the problem: Abdomen Back Leg Other: On a scale of 1-10, with 10 being the	YES LNESS (Please circle	inso	nnswer t	he follow rcle YES	ving questions) or NO to the following Q	YES	
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