Date: _____

Patient Name: _____ **DOB:** ____/____/____

Have you seen Dr. Carlson or Dr. Crocker in the past? Yes No

If Yes, which one? _____

Past Illnesses of Yourself and Family:

You/Your Family	You/Your Family	You/Your Family	You/Your Family
☐ ☐ Glaucoma	☐ ☐ High Cholesterol	☐ ☐ Liver Disease	☐ ☐ Cancer/Tumor
☐ ☐ Heart Disease	☐ ☐ Asthma	☐ ☐ Hepatitis	☐ ☐ Thyroid Disease
☐ ☐ Heart Failure	☐ ☐ Lung Disease	☐ ☐ Kidney Disease	☐ ☐ Epilepsy/Seizures
☐ ☐ Stroke	☐ ☐ Tuberculosis, TB	☐ ☐ Osteoporosis	☐ ☐ Mental Illness
☐ ☐ High Blood Pressure	☐ ☐ Ulcer	☐ ☐ Osteoarthritis	☐ ☐ Depression
☐ ☐ Peripheral Vascular Disease		☐ ☐ Rheumatic Arthritis	☐ ☐ Anemia
☐ ☐ HIV/Immune Disease			

Risk Factors:

Tobacco use

☐ Never ☐ Quit on (date) _____

☐ Current smoker

Packs/day _____ years used _____

Type of tobacco if used

☐ Chew ☐ Pipe

☐ Cigar ☐Smokeless

☐ Cigarettes

Tobacco: Exposure to second-hand smoke? ☐ Yes ☐ No

Alcohol use

☐ Never ☐ Quit on (date) _____

☐ Current

☐ Daily ☐ Frequently ☐ Occasional

☐ Rarely ☐ Social

Diabetes ☐ No ☐ Yes

☐ Type 1 or ☐ Type 2

Year diagnosed _____

Family history of Diabetes ☐ No ☐ Yes

Lifestyle

Diet type _____

Activity ☐ Moderate ☐ Sedentary

☐ Unable to exercise ☐ Vigorous

Type of exercise _____

Frequency ☐ 2-3 times/week ☐ 3-4 times/week

☐ Daily ☐ Never ☐ Occasional

Advance Directive (Please provide copy of document.)

☐ None ☐ Living will

☐ Healthcare proxy ☐ Durable power of attorney

Caffeine: ☐ Yes ☐ No

Types _____ Frequency _____

List all prior illnesses, hospitalizations, and surgeries:

Previous major illnesses and hospitalizations	Year	Previous Surgeries	Year

Date:_____

Patient:_____ **DOB:**_____

Please put a check if you have any of the following symptoms:

General: ○ Fever ○ Fatigue ○ Weight loss ○ Chills ○ Sweats ○ Anorexia ○ Malaise ○ Sleep disorder ○ Tired all the time

CV:

- ○ Chest pain at rest
- ○ Chest pain with exercise
- ○ Palpitations
- ○ Peripheral edema
- ○ PND
- ○ Short of breath
- ○ Short of breath with exertion
- ○ Syncope (passes out)
- ○ Claudication (pain in legs with walking)
- ○ Orthostatic (dizzy when standing)

Resp:

- ○ Cough
- ○ Dyspnea at rest
- ○ Excessive sputum
- ○ Hemoptysis
- ○ Wheezing
- ○ Pleurisy
- ○ Shortness of breath
- ○ History or exposure to TB
- ○ Excessive snoring
- ○ History of sleep apnea
- ○ Daytime sleepiness

Neuro:

- ○ Paralysis
- ○ Paresthesias
- ○ Seizures
- ○ Tremors
- ○ Vertigo
- ○ Dizziness
- ○ Transient blindness
- ○ Frequent falls
- ○ Freq Headaches
- ○ Difficulty walking
- ○ History of TIA's
- ○ Prior CVA

Endo:

- ○ Cold intolerance
- ○ Heat intolerance
- ○ Hair loss

GI:

- ○ Nausea
- ○ Vomiting
- ○ Diarrhea
- ○ Constipation
- ○ Change Bowel habits
- ○ Abdominal pain
- ○ Blood in stool
- ○ Jaundice
- ○ Gas/bloating
- ○ Indigestion
- ○ Abdominal swelling

GU:

- ○ Painful urination (dysuria)
- ○ Blood in urine (hematuria)
- ○ Discharge
- ○ Frequent urination
- ○ Hesitant urination
- ○ Urination frequently at night
- ○ Incontinence
- ○ Decreased libido

MS:

- ○ Back pain
- ○ Joint pain
- ○ Joint swelling
- ○ Muscle cramps
- ○ Muscle weakness
- ○ Stiffness
- ○ Arthritis
- ○ Sciatica
- ○ Restless legs
- ○ Leg pain at night
- ○ Leg pain with exertion

Eyes:

- ○ Blurring
- ○ Diplopia (double vision)
- ○ Irritation
- ○ Discharge
- ○ Vision loss
- ○ Eye pain
- ○ Photophobia (light bothers eyes)

Skin:

- ○ Rash
- ○ Itching
- ○ Dryness
- ○ Suspected lesion

Psych:

- ○ Depression
- ○ Anxiety
- ○ Memory loss
- ○ Suicidal thoughts
- ○ Hallucinations
- ○ Paranoia
- ○ Phobia
- ○ Confusion

Heme:

- ○ Abnormal bruising
- ○ Bleeding
- ○ Enlarged lymph nodes

Allergy:

- ○ Hives (urticaria)
- ○ Allergic rash
- ○ Hay fever
- ○ Recurrent infections

ENT:

- ○ Earache
- ○ Ear discharge
- ○ Tinnitus (ringing)
- ○ Decreased hearing
- ○ Nasal congestion
- ○ Nosebleeds
- ○ Sore throat
- ○ Hoarseness