Heritage Medicine

Name: ____ Today's date: ________________________________

To help us get the most out of today's visit, please answer the following questions:

1. What is your main purpose in coming to our office today? (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be?)
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2. Are you experiencing any of the following symptoms in relation to your main concern?

(Answer "yes" by circling the appropriate symptom.)

Constitutional symptoms: fever, weight loss, fatigue

Eyes: double vision, sudden loss of vision

Ears, nose, mouth and throat: sore throat, runny nose, ear pain

Cardiovascular: chest pain, palpitations

Respiratory: cough, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools

Genitourinary: irregular menses, vaginal bleeding, frequent or painful urination, bloody urine, impotence

Skin: rash, changing mole

Neurological: headache, persistent weakness or numbness on one side of the body, falling

Musculoskeletal: joint pain, muscle weakness

Psychiatric: depression, anxiety, suicidal thoughts

Endocrine: excessive thirst, cold or heat intolerance, breast mass

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Female Hormones: hot flashes, night sweats, mood instability, anxiety, irritability, fatigue, depression, low sex drive, weight gain, poor focus/concentration, memory loss, unrestful sleep

Male Hormones: Erectile dysfunction, low sex drive, lack of stamina, low energy.

3. Do you have any other concerns? Yes (list) No ____

4. Has anything new come up in your family history? (For example, have any of your blood relatives recently developed a new illness?) Yes (list) No

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5. Have you developed any new drug allergies? Yes (list) No ________________________________

6. How much tobacco do you smoke or chew per day? ______________________________________

7. How much alcohol do you consume per week? _ ____

8. How much caffeine do you consume per day? (i.e., coffee, tea, chocolate, soda) ____________________

9. What method of birth control do you use? Not applicable other: ________________________________

10. (Females only): When was your last pap smear? ___________ **Mammo**:________________