



atlanta vanguard
medicalassociates

NAME: _____ **DATE OF BIRTH** _____

PLEASE LET US KNOW YOUR REASON FOR TODAY'S VISIT :

CURRENT MEDICATIONS (WITH DOSAGE) PLEASE INCLUDE VITAMINS AND HERBAL MEDICATIONS:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY (YOUR MEDICAL HISTORY) : Please answer the following as best as you can. Questions with ** are required. Any other medical problems that do not apply may be left blank. Thank you.

** High Blood Pressure	Yes	No		
**Diabetes Mellitus	Yes	No		
**Asthma	Yes	No		
**Congestive Heart Failure	Yes	No		
**Coronary Artery Disease	Yes	No (Please circle which one)		
Angina	Myocardial Infarction (Heart Attack)	Heart Stent	Coronary Bypass Graft (CABG)	
High Cholesterol	Yes	No		
Lung Disease	Yes	No (Please circle which one)		
Asthma	Chronic Obstructive Pulmonary Disease	Pulmonary Fibrosis	Emphysema	
Pulmonary Hypertension	Pulmonary Embolism	Sleep Apnea		
Vascular Disease	Yes	No (Please circle which one)		
Abdominal Aortic Aneurysm	Thoracic Aneurysm	Aortic Dissection		
Heart Valve Problem	Yes	No (Please circle which one)		
Heart murmur	Aortic stenosis	Aortic regurgitation	Mitral regurgitation	
Mitral Valve Prolapse	Mitral Stenosis	Rheumatic Heart Disease	Pulmonic Stenosis	
Vascular Disease of the Brain	Yes	No (Please circle which one)		
Carotid Stenosis	Stroke	Transient Ischemic Attack (TIA)		



PAST MEDICAL HISTORY (YOUR MEDICAL HISTORY) :

Congenital or Structural Heart Disease		Yes	No (Please circle which one)						
Atrial Septal Defect			Ventricular Septal Defect						
Hypertrophic Cardiomyopathy			Other congenital cardiac abnormality						
EKG Abnormalities		Yes	No (Please circle which one)						
Left Bundle Branch Block			Right Bundle Branch Block	AV Block	Wolff-Parkinson White				
Heart Rhythm Problems		Yes	No (Please circle which one)						
Pacemaker			Pacemaker Defibrillator						
Peripheral Vascular Disease		Yes	No (Please circle which one)						
Varicose Veins			Venous Insufficiency	Peripheral Arterial Disease	Peripheral Stents				
Peripheral Artery Bypass Surgery									
Kidney Problems		Yes	No (Please circle which one)						
Impaired kidney function			Renal Failure	Dialysis					
Gastrointestinal problems		Yes	No (Please circle which one)						
Gastritis	Gastric Reflux		Peptic Ulcer Disease	Liver Disease	Irritable Bowel				
Inflammatory Bowel Disease			Crohn's Disease	Diverticulosis					
Endocrine Problems		Yes	No (Please circle which one)						
Hyperthyroidism			Hypothyroidism						
Blood problems		Yes	No (Please circle which one)						
Sickle Cell disease			Anemia	Bleeding Disorders					
Cancer		Yes	No (Please circle which one)						
Breast	Lung		Stomach	Liver	Colon	Leukemia	Lymphoma	Skin	Bone
Infectious Disease		Yes	No (Please circle which one)						
HIV	Hepatitis B		Hepatitis C	Syphilis	Herpes				

ALLERGIES – PLEASE LIST NONE



GYN HISTORY

Last menstrual period _____
 Date of last pap smear _____
 Abnormal paps? Yes No
 Currently sexually active Yes No

OBSTETRICS HISTORY

Total pregnancies _____
 Total children living _____

SURGICAL HISTORY (PLEASE LIST DATES AS WELL) NONE

HOSPITALIZATIONS (PLEASE LIST DATES AS WELL) NONE

FAMILY HISTORY (PLEASE CIRCLE WHICH ONE):

Mother High Blood Pressure Diabetes Coronary Artery Disease Stroke
 Aneurysm Peripheral Vascular Disease Cancer (Type) _____
 Deceased? Alive?

Father High Blood Pressure Diabetes Coronary Artery Disease Stroke
 Aneurysm Peripheral Vascular Disease Cancer (Type) _____
 Deceased? Alive?

Siblings High Blood Pressure Diabetes Coronary Artery Disease Stroke
 Aneurysm Peripheral Vascular Disease Cancer (Type) _____
 How many: Brothers _____ Sisters _____

Children High Blood Pressure Diabetes Coronary Artery Disease Stroke
 Aneurysm Peripheral Vascular Disease Cancer (Type) _____
 How many: Sons _____ Daughters _____



SOCIAL HISTORY

Marital Status : Single Married Divorced Separated Widowed

Occupation: _____

Annual Household Income: <\$50K \$50K-\$100K \$101K-\$250K \$251K-\$500K > \$500K

Tobacco Use:

Are you a:

Current smoker Non-smoker Current every day smoker

Current some day smoker Current status unknown Former smoker

Unknown if ever smoked

How many cigarettes a day do you smoke?

5 or less 6-10 11-20 21-30 31 or more

How long have you been smoking? _____

Are you interested in quitting?

Ready to quit Thinking about quitting Not ready to quit

For former smokers:

When did you quit smoking? _____

How long did you smoke? _____

Alcohol use: Yes No

Did you have a drink containing alcohol in the past year? Yes No

How often did you have 6 or more drinks on one occasion in the past year?

Never Less than monthly Monthly Weekly Daily or almost daily

How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 drinks 3 or 4 drinks 5 or 6 drinks 7 to 9 drinks 10 or more drinks

How often did you have a drink containing alcohol in the past year?

Never Monthly or less 2 to 4 times a month 2 to 3 times a week

4 or more time a week

PREVENTIVE SCREENING - When was the last time you had:

Bone Density _____

Colonoscopy _____

Mammogram _____

Pap Smear _____

Prostate Exam _____

Pulmonary Function Test _____

Testicular Exam _____

Influenza vaccine _____

Pneumonia vaccine _____

Tetanus vaccine _____


REVIEW OF SYSTEMS (PLEASE CIRCLE)

General	NONE	Fatigue	Fever	Headache	Lightheadedness
		Sleep disturbance	Weight gain	Weight loss	Night sweats
Ears/Nose/Throat	NONE	Decreased hearing	Ear pain	Ringing in the ears	
		Sore throat	Swollen glands	Sinus pain	
Endocrine	NONE	Cold intolerance	Heat intolerance	Excessive sweating	Weight loss
		Excessive thirst			
Respiratory	NONE	Cough	Pain with inspiration	Sputum production	Wheezing
Cardiovascular	NONE	Chest pain at rest	Chest pain with exertion	Difficulty laying flat	Dizziness
		Fluid accumulation in the legs	Irregular heartbeat	Shortness of breath	Palpitations
		Shortness of breath with activity	Breathlessness when laying flat	Leg pain with activity	
Gastrointestinal	NONE	Abdominal pain	Constipation	Decreased appetite	Diarrhea
		Nausea	Vomiting	Blood in the stool	Heartburn
		Difficulty swallowing			
Hematology	NONE	Easy bruising	Prolonged bleeding		
Genitourinary	NONE	Blood in the urine	Difficulty urinating	Frequent urination	Pain in the lower back
		Painful urination			
Musculoskeletal	NONE	Painful joints	Swollen joints	Joint stiffness	Muscle aches
Peripheral vascular	NONE	Absent pulses in the feet	Absent pulses in hands	Cold extremities	
		Blanching of the skin	Pain/cramping in the legs with walking	Ulceration of feet	
		Decreased sensation in extremities			
Skin	NONE	Dry skin	Moles	Rash	Scaly lesions of the skin/scalp
				Discoloration	Skin lesion
Neurologic	NONE	Headache	Dizziness	Difficulty speaking	Memory loss
		Tremor	Tinging/numbness	Balance difficulty	Gait abnormality
		Fainting			Transient loss of vision
					Loss of strength
Psychiatric	NONE	Anxiety	Depressed Mood	Stressors	

What is your preferred pharmacy?

Name of Pharmacy _____

Address _____

City, Zip Code _____

Phone Number _____