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)

atlanta vanguard
medicalassociates

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 ☐

_____
_____
_____
_____
_____
_____

atlanta vanguard
medicalassociates

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 _____

atlanta vanguard
medicalassociates

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 _____

atlanta vanguard
medicalassociates

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 Change in bowel habits
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 Transient loss of vision
Tremor Tinging/numbness Balance difficulty Gait abnormality Loss of strength
Fainting

Psychiatric NONE Anxiety Depressed Mood Stressors

What is your preferred pharmacy?
Name of Pharmacy _____
Address _____
City, Zip Code _____
Phone Number _____