Winchester Cardiology and Vascular Medicine P.C.

Please complete each section.

Last name:	First Name:	Middle:	Birth Date:	Age:

Primary care physician (PCP)
Please list other physicians:
Local Pharmacy: Prefer 30 day or 90 day supply?
If used, mail order pharmacy:

Please list ***changes*** to family history by listing family member relationship and medical problem, i.e. heart attack, stroke, hypertension, heart disease, heart failure, etc.

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Tobacco	□ Never	□ Former	□ Current	□ Cigarettes / Amount □ Pipe □ Cigar
Smokeless Tobacco	□ Never	□ Former	□ Current	□ Snuff □ Chew
Alcohol	□ Never	□ Daily	□ Socially	How much weekly?
Exercise	□ None	□ Yes	How often?	What type?

Since your last office visit have you:

Been hospitalized?	
Had procedures/tests?	
Had medication changes?	

Are you planning surgery within the next six months? □ No If yes, what? ______________________

Please check below any NEW or CHANGED symptoms SINCE YOUR LAST OFFICE VISIT.

Constitution:	**Eyes**	**Gastroenterology**	**Endo/Heme/Allergy**
□ Fever □ Chills □ Weight loss □ Malaise/fatigue □ Diaphoresis □ Weakness □ Snoring	□ Blurred vision □ Double vision □ Photophobia □ Eye pain	□ Heartburn □ Nausea □ Vomiting □ Abdominal pain □ Diarrhea □ Constipation □ Blood in stool □ Melena (dark stool)	□ Bruise easily/bleed □ Polydipsia (excessive thirst) **Neurological** □ Dizziness □ Headaches □ Speech change □ Focal weakness □ Seizures □ Loss of consciousness
Skin	**Cardiovascular**	**Urinary**	**Psychiatric**
□ Rash □ Itching **HENT** □ Hearing loss □ Tinnitus □ Ear pain □ Nosebleeds □ Congestion □ Sinus pain □ Sore throat	□ Chest pain □ Palpitations □ orthopnea (unable to lie flat) □ Claudication (pain w/walking) □ Leg swelling □ PND (shortness of breath at night) **Respiratory** □ Cough □ Hemoptysis (blood in sputum) □ Sputum production □ Shortness of breath □ Wheezing	□ Difficulty urinating □ Urgency □ Frequent urination □ Blood in urine □ Flank pain **Musculoskeletal** □ Muscle pain □ Neck pain □ Back pain □ Joint pain □ Falls	□ Depression □ Suicidal ideas □ Substance abuse □ Hallucinations □ Nervous/anxious □ Insomnia □ Memory loss

Do you have painful varicose veins? □ Yes □ No

Patient signature: /Provider signature: Date: