

Your Appointment is Scheduled for:

DAY	TIME

CANCELLATION POLICY

Please inform us at least 72 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients. Please note that we reserve two hours of time with our staff for your appointment, so late cancellations significantly affect us.

Patients who cancel or reschedule less than 72 hours prior to their appointment will be charged a \$200 cancellation fee.

Please contact our office if you have any questions.

APPOINTMENT PREPARATION INSTRUCTIONS

1) Fasting

- Please refrain from eating for eight (8) hours prior to your visit
- Please DO drink water, but avoid all other beverages
- You may take medications with water
- Please refrain from consuming alcohol for 24 hours prior to your visit
- You are welcome to bring a snack to eat after the fasting portions of your tests have been completed. We will have healthy snacks and drinks on hand for you.

2) Clothing

Because your visit includes an EKG, you should wear appropriate clothing.

3) Medical History

Please fill out as much of the Patient Medical History Form as possible prior to your appointment. Some of the questions regarding family history are critical for formulating an accurate “risk score” and providing a comprehensive medical evaluation, and may require inquiry or research. Our staff will assist you in filling out information you have questions about.

PATIENT MEDICAL HISTORY

Please complete this form and bring it with you to your appointment. If you have questions or need assistance, we will review this form with you during your visit.

A detailed family medical history will help our medical providers interpret the history of disease in your family and identify patterns that may be relevant to your own health. This form is needed to assess your risk of certain diseases, determine which diagnostic tests to order as well as type and frequency of screening tests, identify a condition that might not otherwise be considered, and assess your risk of passing a condition on to your children.

1) Demographics

Name	Date of Birth	/	/
Address	Gender		
City	State	Zip	Email address (kept confidential)
Phone #1 ()	<input type="checkbox"/> Check here if you do NOT want email communication		
Phone #2 ()			

2) Social History

Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other:
Living	<input type="checkbox"/> Alone	<input type="checkbox"/> Spouse/Partner	<input type="checkbox"/> Relative	<input type="checkbox"/> Children	<input type="checkbox"/> Other:
Heritage	<input type="checkbox"/> Asian	<input type="checkbox"/> African American	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other:
Occupation:	Job Title/Description:				
Exercise: Do you get 30 min. of steady physical exertion/exercise 3-4 times per week?					<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Walking <input type="checkbox"/> Running		<input type="checkbox"/> Jogging	<input type="checkbox"/> Swimming		
<input type="checkbox"/> Biking <input type="checkbox"/> Household Chores		<input type="checkbox"/> Yard Work	<input type="checkbox"/> Other		
Do you have physical conditions that limit your ability to exercise? <input type="checkbox"/> Y <input type="checkbox"/> N					Specify:
Tobacco Use:	<input type="checkbox"/> Never Used Tobacco	<input type="checkbox"/> Cigarettes	# Per Day	# Of Years	
	<input type="checkbox"/> Ex-Tobacco User	<input type="checkbox"/> Cigars	# Per Day	# Of Years	
	<input type="checkbox"/> Currently Use	<input type="checkbox"/> Pipe	# Per Day	# Of Years	
Alcohol Use:	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, indicate on average how much and check day, week or month			
	_____ Beers per:	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	
	_____ Glasses of wine per:	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	
	_____ Mixed drinks per:	<input type="checkbox"/> Day	<input type="checkbox"/> Week	<input type="checkbox"/> Month	
Family History: Has any blood relative of yours had a heart attack or stroke before the age of 60?					<input type="checkbox"/> Y <input type="checkbox"/> N
Personal History: Have you ever had a heart attack, stroke, stent, cath lab procedure involving your heart?					<input type="checkbox"/> Y <input type="checkbox"/> N

Name: _____ DOB: _____ Date: _____

3) Personal History - 1

Check any of the conditions that you currently have or have had in the past

Please explain if the answer is yes

Cardiovascular

High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N
High cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart failure	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart murmur	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest pain or Angina	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart skips a beat	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart beats too fast	<input type="checkbox"/> Y <input type="checkbox"/> N
Passing out spells	<input type="checkbox"/> Y <input type="checkbox"/> N
Rheumatic fever	<input type="checkbox"/> Y <input type="checkbox"/> N
Feet, ankle or leg swelling	<input type="checkbox"/> Y <input type="checkbox"/> N
Short of breath at rest	<input type="checkbox"/> Y <input type="checkbox"/> N
Short of breath with exercise	<input type="checkbox"/> Y <input type="checkbox"/> N
Short of breath lying down	<input type="checkbox"/> Y <input type="checkbox"/> N
Problems sleeping	<input type="checkbox"/> Y <input type="checkbox"/> N
Sexual dysfunction	<input type="checkbox"/> Y <input type="checkbox"/> N
Frequent urination	<input type="checkbox"/> Y <input type="checkbox"/> N
Abdominal pain	<input type="checkbox"/> Y <input type="checkbox"/> N

Genitourinary

Burning or painful urination	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood in urine	<input type="checkbox"/> Y <input type="checkbox"/> N
Bladder infections	<input type="checkbox"/> Y <input type="checkbox"/> N
Incontinence, dribbling	<input type="checkbox"/> Y <input type="checkbox"/> N
Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> N
Irregular menses (female only)	<input type="checkbox"/> Y <input type="checkbox"/> N

Ears, Nose, Mouth

Loss of smell	<input type="checkbox"/> Y <input type="checkbox"/> N
Nose bleeds	<input type="checkbox"/> Y <input type="checkbox"/> N
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Runny nose	<input type="checkbox"/> Y <input type="checkbox"/> N
Postnasal drip	<input type="checkbox"/> Y <input type="checkbox"/> N
Earache or drainage	<input type="checkbox"/> Y <input type="checkbox"/> N
Hearing loss	<input type="checkbox"/> Y <input type="checkbox"/> N
Ringing in ears	<input type="checkbox"/> Y <input type="checkbox"/> N
Sores in mouth	<input type="checkbox"/> Y <input type="checkbox"/> N

Endocrine

Night sweats	<input type="checkbox"/> Y <input type="checkbox"/> N
Excessive thirst	<input type="checkbox"/> Y <input type="checkbox"/> N

Gastrointestinal

Rectal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N
Blood in stool	<input type="checkbox"/> Y <input type="checkbox"/> N
Loss of appetite	<input type="checkbox"/> Y <input type="checkbox"/> N
Heartburn or indigestion	<input type="checkbox"/> Y <input type="checkbox"/> N
Black or tarry stools	<input type="checkbox"/> Y <input type="checkbox"/> N
Frequent diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N
Difficulty Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N
Nausea or vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N
Vomiting of blood	<input type="checkbox"/> Y <input type="checkbox"/> N
Chronic constipation	<input type="checkbox"/> Y <input type="checkbox"/> N
Stomach ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N

Name: _____ DOB: _____ Date: _____

3) Personal History - 2

Check any of the conditions that you currently have or have had in the past

Please explain if the answer is yes

Head and neck

Swelling in neck	<input type="checkbox"/> Y <input type="checkbox"/> N
Prolonged hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> N
Pain or stiffness in neck	<input type="checkbox"/> Y <input type="checkbox"/> N

Eyes

Glasses or contacts	<input type="checkbox"/> Y <input type="checkbox"/> N
Double, failing vision	<input type="checkbox"/> Y <input type="checkbox"/> N
Dry eyes	<input type="checkbox"/> Y <input type="checkbox"/> N
Pain or light sensitivity	<input type="checkbox"/> Y <input type="checkbox"/> N

Musculoskeletal

Swollen or red joints	<input type="checkbox"/> Y <input type="checkbox"/> N
Poor leg circulation	<input type="checkbox"/> Y <input type="checkbox"/> N
Arm or leg weakness	<input type="checkbox"/> Y <input type="checkbox"/> N
Leg cramps	<input type="checkbox"/> Y <input type="checkbox"/> N
Difficulty in walking	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Inflammatory Disease (psoriasis)	<input type="checkbox"/> Y <input type="checkbox"/> N

Neurologic

Light headed or dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N
Speech disturbances	<input type="checkbox"/> Y <input type="checkbox"/> N
Convulsions or seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Numbness or tingling	<input type="checkbox"/> Y <input type="checkbox"/> N
Frequent headaches	<input type="checkbox"/> Y <input type="checkbox"/> N
Memory loss	<input type="checkbox"/> Y <input type="checkbox"/> N
Paralysis or weakness	<input type="checkbox"/> Y <input type="checkbox"/> N

Skin

Rash, dryness, itching	<input type="checkbox"/> Y <input type="checkbox"/> N
Change in nails or skin color	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding, bruising tendencies	<input type="checkbox"/> Y <input type="checkbox"/> N

Lungs

Cough with sputum or blood	<input type="checkbox"/> Y <input type="checkbox"/> N
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N

Psychiatric

Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N
Nervous breakdown	<input type="checkbox"/> Y <input type="checkbox"/> N
Alcohol problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Physical, verbal, sexual abuse	<input type="checkbox"/> Y <input type="checkbox"/> N

Misc.

Fever or chills	<input type="checkbox"/> Y <input type="checkbox"/> N
Recent weight change	<input type="checkbox"/> Y <input type="checkbox"/> N
Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N
Heat or cold intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N
Recent changes in mood	<input type="checkbox"/> Y <input type="checkbox"/> N

Please include any other conditions you would like to discuss with the medical provider:

Name: _____ DOB: _____ Date: _____

4) Weight / Dieting History

Do you want to change your eating habits?

Y N Why? _____

Have you tried to lose weight before?

Y N How many times? _____

Are you currently on a special diet?

Y N Specify _____

Have you used any diet programs in the past?

Y N Which ones? _____

What was your weight at age 20? (in pounds)

_____ | _____

Are members of your family overweight?

Explain _____

Fill in the box of the number closest to your best estimate of servings per day

Foods with fat/cholesterol (fried foods, fatty meats, junk food) 0 1 2 3 4 or more

Fruits and vegetables (4 cups cooked, 1 cup raw) 0 1 2 3 4 or more

Caffeine (1 cup coffee, soda etc.) 0 1 2 3 4 or more

Calcium servings (dairy foods, 8oz. milk, yogurt, cheese, ice cream) 0 1 2 3 4 or more

5) Past Surgeries, Procedures & Diagnostic Tests

List past testing, hospital visits & surgeries (for example: stent, cath procedure, heart surgeries, exercise tests, heart scan, MRI, CT scan etc.)
PLEASE DO NOT WRITE "My physician has copies of all tests"

Surgery Type/Diagnostic Test	Current Problem?	Date	Physician or Hospital where procedure took place
Example: Brain surgery	<input type="checkbox"/> Current <input checked="" type="checkbox"/> Past	May 12, 1988, May 1988	Dr. Brainsurgeon, Houston
	<input type="checkbox"/> Current <input type="checkbox"/> Past		
	<input type="checkbox"/> Current <input type="checkbox"/> Past		
	<input type="checkbox"/> Current <input type="checkbox"/> Past		
	<input type="checkbox"/> Current <input type="checkbox"/> Past		

Comments/Notes: _____

6) Allergies

List allergies & type of reaction. Include medications, food, & seasonal & environmental allergies (for example: animals, latex, smoke, etc.)

No Known Allergies or Never have Been Diagnosed with any Allergies

Allergy to	Description of Reaction
Example: Peanut allergy	Hives and Rash
1.	4.
2.	5.
3.	6.

Living to the best of your health.

Name: _____ DOB: _____ Date: _____

7) Past & Current Medical Problems

List all medical problems for which you are currently being treated or have previously been treated
Include all diseases and illnesses you hav been told you have or are being treated for

8) Medications

List type and amount of medications you use on a regular basis

Include prescription, over-the-counter, birth control, hormones, vitamins, herbs, nutritional supplements and recreational drugs

Name: _____ DOB: _____ Date: _____

9) Family History

Please complete as much of this section as possible

You can also bring your family history with you and we will enter the information into the chart below for you

Adopted? Y N

Medical Condition	Father	Mother	Brother	Sister	Son	Daughter	Grandparents	(PGF, PGM, MGF, MGM)	Comments	
Indicate approximate age disease first was identified										
High blood pressure	age	age	age	age	age	age	age			
High Cholesterol	age	age	age	age	age	age	age			
Diabetes (type 1 or 2)	age	age	age	age	age	age	age			
Heart Attack	age	age	age	age	age	age	age			
Heart Failure	age	age	age	age	age	age	age			
Heart surgery/stent/balloon	age	age	age	age	age	age	age			
Angina (heart pain)	age	age	age	age	age	age	age			
Leg circulation problem	age	age	age	age	age	age	age			
Failing kidneys	age	age	age	age	age	age	age			
Stroke	age	age	age	age	age	age	age			
Smoking	age	age	age	age	age	age	age			
Dementia/Alzheimer's	age	age	age	age	age	age	age			
Alcoholism	age	age	age	age	age	age	age			
Arthritis	age	age	age	age	age	age	age			
Birth Defects	age	age	age	age	age	age	age			
Hearing Problems	age	age	age	age	age	age	age			
Sudden Death	age	age	age	age	age	age	age			
Genetic Diseases	age	age	age	age	age	age	age			
Age & L=living D=deceased	Father	Mother	Brother	Sister	Son	Daughter	Grandparents			
							PGF	PGM	MGF	MGM

*PGF = paternal grandfather; PGM = paternal grandmother; MGF = maternal grandfather; MGM = maternal grandmother

Please include any other details related to your family history or concerns you would like to discuss with our providers:

Name: _____ DOB: _____ Date: _____

10) Phase of Life - women only

Check all boxes that apply to you

Date of last menstrual period (LMP)			
Menopause:	<input type="checkbox"/> Pre-menopausal	<input type="checkbox"/> Experiencing menopause	<input type="checkbox"/> Other, N/A

Please include any other details related to your family history or concerns you would like to discuss with our providers:

11) How Did You Hear About Us?

- Physician referral
- Radio
- Print advertisement
- Television
- Internet
- Word of Mouth
- Other _____

Would you like us to send your results to another health care provider? Y N

If so, we will need his or her first and last names and complete address:

Provider's name: _____
Clinic name: _____
Street address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Fax: (_____) _____

Patient Signature:



We take your health history as being very important. We trust you do too!
Our clinic endeavors to offer the best care available.

Internal Purposes Only

History reviewed by: _____

Name: _____ DOB: _____ Date: _____

SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Chance of dozing

Sitting and reading	<input type="text"/>
Watching TV	<input type="text"/>
Sitting and talking to someone	<input type="text"/>
Sitting quietly after a lunch without alcohol	<input type="text"/>
Sitting, inactive in a public place (e.g. a theatre or a meeting)	<input type="text"/>
As a passenger in a car for an hour without a break	<input type="text"/>
Lying down to rest in the afternoon when circumstances permit	<input type="text"/>
In a car, while stopped for a few minutes in the traffic	<input type="text"/>
TOTAL	<input type="text"/>

0-10 = Normal

10-12 = Borderline

12-24 = Abnormal

Name: _____ DOB: _____ Date: _____

STRESS QUESTIONNAIRE - page 1

	Never	Seldom	Sometimes	Often	Regular
Heart pounding or racing	0	1	2	3	4
Trembling/shaking	0	1	2	3	4
Grinding of teeth (even in your sleep)	0	1	2	3	4
Do not sleep well	0	1	2	3	4
Susceptible to illness	0	1	2	3	4
Stomach pains	0	1	2	3	4
Headaches	0	1	2	3	4
Migraine headaches	0	1	2	3	4
Feeling tired constantly	0	1	2	3	4
Constipation	0	1	2	3	4
Hollow stomach	0	1	2	3	4
Lowered self-confidence	0	1	2	3	4
Loss of appetite	0	1	2	3	4
Excessive sweating (e.g. hands, face, arm pits etc.)	0	1	2	3	4
Sweaty palms	0	1	2	3	4
Listlessness - don't feel like doing stuff	0	1	2	3	4
Forget things	0	1	2	3	4
Absent-minded	0	1	2	3	4
Feeling irritated	0	1	2	3	4
Nauseous	0	1	2	3	4
Considered suicide	0	1	2	3	4
Pessimistic	0	1	2	3	4
Jealous/Envious	0	1	2	3	4
Moody	0	1	2	3	4
Pain in lower back	0	1	2	3	4
Feelings of depression	0	1	2	3	4
Anxiety	0	1	2	3	4
Loss of interest in things	0	1	2	3	4
Sensitive and/or touchy	0	1	2	3	4
Muscle pain	0	1	2	3	4
Indecisive	0	1	2	3	4
Unnecessary/excessive checking of work	0	1	2	3	4
Difficulty with breathing	0	1	2	3	4
Struggle to overcome minor illness (e.g. a cold)	0	1	2	3	4
Suspicious	0	1	2	3	4
Wasting time on irrelevant activities	0	1	2	3	4
Cannot discuss my problems with others	0	1	2	3	4
Hair loss	0	1	2	3	4
Total score:					

Name: _____ DOB: _____ Date: _____

STRESS QUESTIONNAIRE - page 2

	Never	Seldom	Sometimes	Often	Regular
Throat irritations	0	1	2	3	4
Lost sense of humor	0	1	2	3	4
Impaired concentration	0	1	2	3	4
Struggle to lose/gain weight even when following a diet	0	1	2	3	4
Heartburn	0	1	2	3	4
Skin disorders	0	1	2	3	4
Don't take the initiative you used to	0	1	2	3	4
Nightmares	0	1	2	3	4
Dry mouth	0	1	2	3	4
Consumption of energy drinks (e.g. Red Bull, 5-hour energy etc.)	0	1	2	3	4
Diarrhea	0	1	2	3	4
Nervous twitches in face and scalp	0	1	2	3	4
Feelings of inadequacy	0	1	2	3	4
Easily startled/jumpy	0	1	2	3	4
Increased appetite	0	1	2	3	4
Impaired coordination	0	1	2	3	4
Uncertainty	0	1	2	3	4
Become frustrated quickly	0	1	2	3	4
Less involvement with others	0	1	2	3	4
Biting of fingernails	0	1	2	3	4
Reduced motivation	0	1	2	3	4
Increased caffeine intake (coffee, tea, soda etc.)	0	1	2	3	4
Restlessness	0	1	2	3	4
Poor judgement	0	1	2	3	4
Increased smoking	0	1	2	3	4
Feeling out of control	0	1	2	3	4
Confused thoughts	0	1	2	3	4
Increased time sleeping	0	1	2	3	4
Use tranquilizers, sleeping pills	0	1	2	3	4
Wake up tired	0	1	2	3	4
Feeling overwhelmed by demands	0	1	2	3	4
Excessive blinking	0	1	2	3	4
Daydreaming	0	1	2	3	4
Procrastination	0	1	2	3	4
Feeling panicky	0	1	2	3	4
Difficult to identify causes of nonperformance	0	1	2	3	4
Reduced productivity	0	1	2	3	4
Total score:					

SYMPTOM SURVEY

Name: _____ DOB: _____ Date: _____

	Worse ☹.....☺.....Better									
Energy	<input type="checkbox"/>									
Sleep	<input type="checkbox"/>									
Mood (depression, stress, anxiety)	<input type="checkbox"/>									
Pain	<input type="checkbox"/>									
							Never	Mild	Moderate	Severe
Joint or muscle aches.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed mood or anxiety.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Declining mental ability / focus / concentration.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes / irritability.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased muscle strength.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased libido / desire.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in sexual performance / climax.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid hair loss.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin changes / dry or wrinkled skin.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling or bloating.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain / unable to lose weight.....							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Women Only:

Intimacy dryness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes or night sweats.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>