

Kettering Cardiothoracic and Vascular Surgeons, Inc. / Alliance Physicians, Inc.

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Name: _____ DOB: _____ Date: _____

Reason for office visit: _____

Circle Yes or No on each question:

<u>EYES</u>		<u>ENDOCRINE</u>		<u>URINARY</u>	
Glaucoma	Y N	Thyroid disease	Y N	Kidney problems	Y N
Loss of vision	Y N	Diabetes	Y N	Prostrate enlargement	Y N
Black spots/floater	Y N	<u>HEMATOLOGY/LYMPHATIC</u>		Painful urination	Y N
<u>EARS/NOSE/THROAT</u>		Bleeding/bruising	Y N	<u>ORTHOPEDIC</u>	
Hearing loss	Y N	Poor blood clotting	Y N	Arthritis	Y N
Difficulty swallowing	Y N	Anemia	Y N	Gout	Y N
<u>CARDIOVASCULAR</u>		Hepatitis Type: ____	Y N	Back pain	Y N
Chest pain	Y N	HIV/AIDS	Y N	Artificial joint	Y N
Irregular or fast heart	Y N	Blood transfusion	Y N	Leg cramps w/walking	Y N
Previous MI / Stent	Y N	Liver disease	Y N	<u>OTHER PROBLEMS</u>	
High blood pressure	Y N	<u>NEUROLOGIC</u>		Recent weight change	Y N
Rheumatic fever	Y N	Fainting	Y N	Mental health history	Y N
Heart/Valve disease	Y N	Seizure-epilepsy	Y N	Sleep apnea	Y N
<u>RESPIRATORY</u>		Stroke	Y N	Fevers	Y N
Chronic/frequent cough	Y N	Numbness of limbs	Y N	Chills	Y N
Shortness of breath	Y N	Light headedness	Y N	Night sweats	Y N
Asthma	Y N	<u>GASTROINTESTINAL</u>		Cancer	Y N
Tuberculosis	Y N	Nausea /vomiting	Y N		
Emphysema	Y N	Abdominal pain	Y N		
<u>SKIN</u>		Reflux	Y N	<u>SOCIAL HISTORY:</u>	
Skin rashes	Y N	Peptic ulcer	Y N	Tobacco	Y N
Skin lesions	Y N	Constipation/Diarrhea	Y N	Packs per day _____ for _____ years	
				Alcohol	Y N
				Drinks per day _____	

HISTORY OF OPERATIONS:

Year	Operation

FAMILY HISTORY: Has any blood relative had any of the following health issues, answer yes or no and list relationship

		Relationship		Relationship
Bleeding tendency	Y N	_____	Cancer	Y N _____
Diabetes	Y N	_____	Aneurysms	Y N _____
High blood pressure	Y N	_____	Heart disease	Y N _____
Stroke	Y N	_____	Tuberculosis	Y N _____

******TURN PAGE OVER AND COMPLETE OTHER SIDE******

Name: _____ Date: _____

****ALLERGIES****: _____

IF YOU HAVE A WRITTEN OR TYPED MEDICATION LIST

PLEASE GIVE LIST TO RECEPTIONIST TO COPY

(YOU DO NOT NEED TO COMPLETE MEDICATION LIST)

MEDICATION / DOSAGE	OFFICE USE ONLY	DATE	DATE	DATE
ASPIRIN				
COUMADIN (WARFARIN/JANTOVEN)				
PLAVIX (CLOPIDAGREL)				