Conrad Pearson Patient Check-In Questionnaire

Patient Name: _____ Occupation: _____

Who is your primary care physician? _____

Who is your Cardiologist? _____

What specific problems do you want to address today in the office?

(Check here ___ if today's visit is only for a routine yearly check-up)

1) _____
2) _____
3) _____

Are you allergic to any medicines? Yes / No Please list: _____

How tall are you? _____ How much do you weigh? _____

Have you been discharged from any hospital in the last 30 days? Yes / No _____ (hospital)

Have you had any CT scans, MRI, Ultrasounds, or PSA tests recently? Yes / No

If yes, where _____

Government Required Questions:

When was your last flu shot? _____ Date (as best you recall)

When was your last pneumonia shot / pneumovax? _____ Date

Do you have a "Living Will"? Yes / No

Have you ever smoked cigarettes? Yes / No

When did you quit? _____

Do you drink alcohol (beer, wine, or hard liquor)? Yes / No

How much? _____ how often? _____

What is your pharmacy name and phone number? _____

Do you use a mail order pharmacy? Yes / No _____ (which one)

What medications are you currently taking? (Including aspirin, vitamins, supplements)

(Please have a list ready for the nurse in the back, or write them here)

□ **None**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Conrad Pearson Patient Check-In Questionnaire

-OVER-

Are you experiencing any of the following symptoms currently? (Check all that apply)

- ☐ Fever
- ☐ Chills
- ☐ Blurred Vision
- ☐ Dry Eyes
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloody Urine
- ☐ Urinary Leakage
- ☐ Dry Mouth
- ☐ Fatigue
- ☐ Hot Flashes
- ☐ Headache
- ☐ Seizures
- ☐ Anxiety
- ☐ Depression
- ☐ Itching Skin
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Easy Bleeding
- ☐ Swollen glands

Conrad Pearson Patient Check-In Questionnaire

(Front and Back)

Medical History

Are you being treated for any of the following:

- ☐ Cardiac Disease (includes prior heart attack)
- ☐ Congestive Heart Failure
- ☐ Hypertension (high blood pressure)
- ☐ Irregular heart rhythm (includes A FIB)
- ☐ Prior Blood Clots (DVT or Pulmonary embolism)
- ☐ Prior Chemotherapy
- ☐ Diverticulosis
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Heart Valve Disease
- ☐ Kidney Stones
- ☐ Stroke
- ☐ Lung Disease (COPD)
- ☐ Prior radiation therapy
- ☐ GERD / Stomach ulcers
- ☐ Thyroid Disorder
- ☐ Cancer: what type: _____
- ☐ Others: please list _____
- ☐ None

Surgical History

Have you ever had surgery before?

- ☐ Abdominal aneurysm repair
- ☐ Hysterectomy
- ☐ Colon Removal
- ☐ Mesh Implant
- ☐ Heart Stent
- ☐ Heart Bypass
- ☐ Hip Replacement
- ☐ Appendix Removal
- ☐ Hernia Repair
- ☐ Pacemaker / Defibrillator
- ☐ Gallbladder removal
- ☐ Heart valve replacement
- ☐ Knee Replacement
- ☐ Cancer surgery: _____
- ☐ Other: please list _____
- ☐ None

Do you have a family history of any of the following? Check in the table if yes (including deceased)

	Kidney Stones	Breast Cancer	Bladder Cancer	Colon / Rectum Cancer	Prostate Cancer	Kidney Cancer
Brother						
Sister						
Mother						
Father						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

-OVER-