DAVID D. VAN SLOOTEN, M.D.
LORRAINE S. LIRA, M.D.
PATRICIA G. KLEIN, M.D.

~ Welcome to Our Office! ~

Name _____ **Date** _____/_____/_____

Age: _____ **Height:** _____ **Weight:** _____ **Right or Left Handed**
Circle One

What is the problem you're seeing the doctor for today?

_____

_____

_____

When did it start?

_____

Have you had any treatment?

_____

_____

Have you had any tests such as blood tests, MRI or CAT scan? If yes, please advise when & where.

_____

_____

Do you have any other problems? **Please CIRCLE those you have and add any others.**

High blood pressure; Diabetes; High cholesterol; Headaches; Dizziness; Vision problems; Loss of hearing; Trouble speaking; Memory problems; Balance problems; Falls; Pain; Fainting; Stomach problems; Bowel problems; Anemia; Kidney problems; Liver problems; Urinary problems; Lung problems; Heart problems; Fatigue; Stroke; Head injury; Fractures; Numbness or tingling; Cancer, Seizures; Leg or lung clots?

_____

_____

Have you had surgery? Please list any below.

_____

_____

Do you have an Advanced Health Care Directive / Living Will ? YES or NO

LLW 3/16

TURN OVER →

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Please list all the Prescribed Medications and Over-the-Counter Medications or Supplements you are taking. You can provide us with a copy.

_____

_____

Have you been in the hospital recently? YES or NO

Why? _____ **Where?** _____

Are you working or retired? _____

What kind of work have you done? _____

Did you Serve in the Military? _____

Who is living at home with you? _____

Please list any family diseases.

Mother: _____

Father: _____

Brother: _____

Sister: _____

Other (Specify): _____

Do you smoke? YES or NO. If so, when did you stop? _____

How long did you smoke? _____ **How many packs per day?** _____

Do you drink alcohol? YES or NO. If so, how much do you drink? _____

Do you drink caffeine such as coffee, tea, soda, energy drinks? _____

If so, how much per day? _____

Do you have any allergies? YES or NO. Please list them.

_____

Are there any other concerns? _____

LLW 7/15

TURN OVER →