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?
1) _____
2) _____
Height: _____Weight_____
Are you allergic to any medicines? Yes / No Please list: _____

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 _____

What pharmacy do you prefer? _____ Pharmacy Phone: _____
What Mail Order Pharmacy do you use? _____

Do you have a "Living Will" or "Advance Directive"? Yes / No

Do you Smoke Cigarettes / Pipe? Yes / No Have you ever? Yes/No When did you stop? _____

Are you taking any weight loss medications? Yes / No

Are you taking any blood thinners? Yes / No

****Please update the following information yearly, or if there have been changes since your last visit.**

What medications are you currently taking? (Including aspirin, vitamins, supplements)
(Please have your list from home ready, or write them here)

☐ **None**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

-OVER-

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

- ☐ Fever
- ☐ Chills
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloody Urine
- ☐ Urinary Leakage
- ☐ Dry Mouth
- ☐ Fatigue
- ☐ Easy Bleeding
- ☐ Swollen glands

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 Clot (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 _____
- ☐ Sleep Apnea

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						