Pulse MD

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www.mypulsemds.com

Name: _____ Sex: M F DOB: _____

What brings you to see me today?

Do YOU have any drug allergies: □ Penicillin □ Sulfa □ Tetracycline □ _____

Family Health History

This pertains to **YOUR BLOOD (genetic) relatives ONLY**

Relative Type	Living (L) or Deceased (D)	Current age/age @ death	Cause of death	Health condition you wish me to know about
Father				
Mother				
Brother (s)				
Sister (s)				
Mother's Father				
Mother's Mother				
Father's Father				
Father's Mother				
Child(ren)				
□ I was adopted				

Your Chronic Medical Condition(s)

Please indicate year diagnosed and pertinent additional information

Cardiovascular: ○ CAD ○ CHF ○ Heart Attack ○ Pacemaker ○ Defibrillator ○ A Fib ○ Heart Arrythmia ○ Hypertension ○ High Cholesterol ○ DVT/PE ○ Peripheral Vascular Disease ○ Valvuar Disease	**Pulmonary:** ○ COPD ○ Bronchitis ○ Asthma ○ Sleep Apnea
Endocrine: ○ Diabetes ○ Hypothyroidism ○ Hyperthyroidism	**Autoimmune** ○ Rheumatoid Arthritis ○ Psoriasis ○ Lupus
Neurology: ○ Seizures ○ Stroke ○ Epilepsy ○ TIA ○ Dementia ○ Alzheimer's Disease ○ Neuropathy ○ Migraines ○ Parkinson's Disease ○ Other: _____	**Orthopedic:** ○ Gout ○ Osteoarthritis ○ Osteoporosis ○ Sciatica
Gastrointestinal: ○ GERD/Acid Reflux ○ Cirrhosis ○ Hepatitis A B C ○ Gastritis ○ Diverticulosis ○ Hemorrhoids ○ IBS	**Psych:** ○ Anxiety ○ Depression ○ PTSD

Name: _____ Sex: M F DOB: _____

Review of Systems

Please circle all that you have experienced within the **past 6 months**

Fever / Chills	Dizziness/ spinning	Fainting	Forgetfulness	Headache
Sweating	Weakness	Weight loss/ gain	Numbness	Nervousness
Loud snoring	↑ Daytime sleepiness	Trouble sleeping	Imbalance	Hives/ rash
Diarrhea	Indigestion/ heartburn	Constipation	Nausea	Vomiting
Rectal bleeding	Dark colored stools	Abdominal pain	↑ Urination	Blood in urine
Painful urination	Incontinence (leakage)	Trouble swallowing	Bruising	Itching
Change in skin	Non- healing sores	Vision changes	Earaches	Loss of hearing
Discharge of ear	Hoarseness	Ringing in ears	Nosebleeds	Sore throat
Sinus issues	Teeth / gum concerns	Congestion	Cough	Shortness of breath
Palpitations	Chest pain/ discomfort	Leg swelling	Varicose veins	Pain in legs with walking
↑ Thirst	↑ Hunger	Cold/ burning feet	Joint pain	Breast / nipple discharge
Vaginal discharge	Breast lump	Penial discharge	Testicle lump	Painful intercourse

Smoking History: ☐I was NEVER a smoker ☐CURRENT smoker ☐FORMER smoker

I currently smoke: ____ (number of packs daily) for ____ (number of years)

I did smoke: ___ (number of packs daily) for ___(number of years) & quit in _____(enter year)

Alcohol History: ☐I have never ☐I am a current drinker ☐I drank but now do not

I currently drink____ (number of alcoholic beverages) ☐Daily ☐Weekly ☐Monthly

Previously I drank ___ (number of alcoholic beverages) ☐Daily ☐Weekly ☐Monthly

I quit in _____ (enter year). I have attended AA in past ____ NO ___ YES

Illicit Drug History: I have used illicit drugs: ☐ NEVER ☐CURRENTLY ☐ IN PAST

Type of drug: ☐Marijuana ☐Cocaine ☐Methamphetamine ☐Heroin

☐Other: _____

Prevention & Maintenance of your Health

Please provide date of the **MOST RECENT** injection/ procedure

Type	MM/DD/YYYY	Type	MM/DD/YYYY	Type	MM/DD/YYYY
Flu Vaccine		Mammogram		Heart Cath	
Pneumonia Vaccine		Pap Smear Last Menses: Hysterectomy: Y N		ECHO (ultrasound of heart)	
Shingles		Bone Density (DEXA)		Stress test	
Hep B series		Colonoscopy Polyps: Y N		Chest Xray	
Eye Exam		Endoscopy (EGD) Barrett's Y N		Prostate Exam/ PSA	

Blood Transfusion (s)

Please list dates & reason for transfusion (s)

Date (s)	Reason

Hospitalizations in the past 1 year

Reason for hospitalization	Date

Surgical History (All major surgeries)

Procedure Type	Date

Name: _____ Sex: M F DOB: _____

Fractures

Type/ Bone	Date

Please list all medications in the following tables. Please pay attention to table headings.

OVER THE COUNTER MEDICATION (S)

Name of medication	Dose	How many times a day
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed

PHYSICIAN PRESCRIBED MEDICATION(S)

Name of medication	Dose	How many times a day
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed
		1 2 3 4 □ as needed

Other Providers Participating in My Healthcare

Type	Name of Doctor	Phone number
Cardiologist		
Dermatologist		
ENT ear/nose/throat)		
Gastroenterologist		
GYN		
Nephrologist		
Oncologist		
Ophthalmologist		
Orthopedist		
Psych (counselor)		
Pulmonologist		
Rheumatologist		
Urologist		

My last Primary Care Doctor was:

Name:_____

Phone Number:_____

Name: _____ Sex: M F DOB: _____

Sleep Scale

Date this form was completed: _____

Over the past **SIX (6) months**,
how likely are you to doze off or fall asleep in the following situations?

Please use the following scale to select your most appropriate number for each listed situation.

0= would never doze

1= slight chance of dozing

2= moderate chance of dozing

3= high chance of dozing

Situation	**Chance of dozing (select # from above)**
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (theater/meeting)	_____
As a passenger in a care x 1 hour without a break	_____
As a driver in a car, while stopped in traffic	_____
Lying down to rest in the afternoon	_____
Sitting and chatting with a friend	_____
Sitting quietly after lunch without alcohol	_____

TOTAL: _____