

Drugs previously tried for principal complaint but not currently taking

Name with dose and frequency	Reason for stopping	Prescribing MD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other issues:	Yes	No
Do you feel excessive fatigue, tiredness, or bad in general?	_____	_____
Recent change in weight?	_____	_____
Recent fever?	_____	_____
Headaches?	_____	_____
Double vision or change in vision?	_____	_____
Shortness of breath at rest?	_____	_____
Shortness of breath with exercise?	_____	_____
Do you have a regular exercise routine?	_____	_____
Chest pain at rest (or not exercise related?)	_____	_____
Chest pain with exercise?	_____	_____
Diagnosed with cardiac disease?	_____	_____
Problems with nausea?	_____	_____
Problems with inability to control stools (incontinence)?	_____	_____
Problems with inability to control urine (incontinence)?	_____	_____
Problems with sexual activity (if currently sexually active)?	_____	_____
Problem with neck pain or arm pain?	_____	_____
Problem with low back pain or leg pain?	_____	_____
Do you feel that you are depressed?	_____	_____
Do you feel that you are overly anxious?	_____	_____
Do you wake up feeling refreshed?	_____	_____
Do you snore?	_____	_____
If female, do you have regular menstrual cycles?	_____	_____

Past Medical History (attach additional page if needed)

Other Medical Conditions	Date of Onset	Treating MD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past surgeries	Date performed	MD performed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diseases that run in your immediate family (parents, brother, sisters, children)

Does anyone in your immediate or extended family have the same condition or symptoms for which you are seeing Dr. Loftus?

Do you currently smoke or use any tobacco product? _____

Have you smoked greater than 100 cigarettes in your lifetime? _____

How much alcohol do you typically drink? _____

How much caffeine do you typically drink? _____

Have you used, or currently use, any illegal substances? _____

Please list the physicians you would like us to keep up to date on your care.

Name	Phone	Fax
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any other information you would like to tell us?
