

ANGELA N. HUTZENBUHLER, M.D.
PATIENT INFORMATION PROFILE

Patient _____ Date _____

Please check (√) if you have had any of the following problems:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> acid reflux | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney problems |
| <input type="checkbox"/> anemia | <input type="checkbox"/> diverticular disease | <input type="checkbox"/> migraines |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> emphysema | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> gallstones | <input type="checkbox"/> seizures |
| <input type="checkbox"/> asthma | <input type="checkbox"/> heart disease | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> cancer _____ | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> stroke / TIA |
| <input type="checkbox"/> colon polyps | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> depression | <input type="checkbox"/> hepatitis | <input type="checkbox"/> other _____ |

ALLERGIES:

Past surgeries / date(s)

Medications / dose(s)

None

None

FAMILY MEDICAL HISTORY

(List family member)

Colon cancer _____
 Breast cancer _____
 Stomach cancer _____
 Breast cancer _____
 Diabetes _____
 Heart Disease _____
 Other _____

SOCIAL HISTORY

Tobacco (per day) _____
 Alcohol (per week) _____
 Caffeine (per day) _____
 Occupation _____

REVIEW OF SYSTEMS

Please place a check () if you currently have any of the following symptoms:

GENERAL

- weight loss
- fever
- fatigue
- none of the above

EYES

- glaucoma/eyesight
- none of the above

EAR/NOSE/THROAT

- nose/sinuses
- mouth
- throat/hoarseness
- none of the above

CARDIOVASCULAR

- chest pain
- leg pain w/ walking
- heart racing
- ankle swelling
- none of the above

RESPIRATORY

- shortness of breath
- persistent cough
- wheezing
- none of the above

ENDOCRINE

- increased thirst
- increased urination
- none of the above

GASTROINTESTINAL

- heartburn
- trouble swallowing or food sticking
- loss of appetite
- nausea/vomiting
- diarrhea
- change in bowel habits
- constipation
- black/tarry stools
- rectal bleeding
- jaundice
- none of the above

SKIN

- rash
- bruising
- none of the above

MUSCULOSKELETAL

- trouble walking
- trouble standing
- joint/muscle pain
- none of the above

ALLERGY/IMMUNE SYSTEM

- allergies
- frequent urination
- none of the above

CANCER

- Type: _____

- none

NEUROLOGICAL

- memory difficulty
- speaking difficulty
- headaches
- numbness
- temporary blindness
- none of the above

PSYCHIATRIC

- depression
- anxiety
- hearing voices
- suicidal thoughts
- none of the above

BLOOD/LYMPHATIC

- swollen glands
- frequent nosebleeds
- easy bruising
- none of the above

GENITOURINARY

- pain with urination
- excessive urination
- trouble starting urinary stream
- blood urine
- none of the above

Patient signature: _____ Date: _____

The above information has been reviewed with the patient:

Physician signature: _____ Date: _____