4560 S. Eastern Ave. Suite 14
Las Vegas, NV 89119
702.586.5060 | www.SilverArcAPN.com

Patient Introduction

Personal History:

Your Name: _____
First Middle Last

Your Address:

_____
Street

_____
City/State Zip

Telephone: Home:_____ Bus: _____

Email Address: _____

Birth Date: Month: _____ Day: _____Year:_____

Marital Status:_____

Occupation: _____

Employer: _____

Present MD: _____
City: _____

Referred to our center or seminar by:

Thank You!

Insurance Information

(Used only for lab tests and pharmacy, if needed)

Primary insurance: _____

Subscriber name: _____

Subscriber number: _____

Subscriber date of birth: _____

Relationship to the patient: _____

Group#: _____ Plan type: _____

Co-pay: _____ Effective Date: _____

Ins. street address: _____

City, State ZIP: _____

Secondary insurance: _____

Subscriber name: _____

Subscriber number: _____

Subscriber date of birth: _____

Relationship to the patient: _____

Group#: _____ Plan type: _____

Co-pay: _____ Effective Date: _____

Ins. street address: _____

City, State ZIP: _____

HEALTH QUESTIONNAIRE

NAME: _____

PHARMACY/LOCATION: _____ Phone# _____ Fax: _____

REASON FOR VISIT: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

ALLERGIES? (medications, foods, seasonal etc.)

_____

Do you have pets? ◯ No ◯ Yes: Type: _____

Family Medical Problems:

Father: _____ Sisters: _____

Mother: _____ Brothers: _____

Medical Problems/Hospitalizations / Surgeries:

Date:	**Date:**
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Medications: (include BCP, calcium, vitamins, aspirin, herbs)

Dosage: _____ Dosage: _____

Dosage: _____ Dosage: _____

Last Menstrual Period: _____ Birth Control Method: _____

Social History: Occupation: _____ Live with: ◯ Spouse ◯ Alone ◯ Family ◯ Other _____

Alcohol use: ◯ No ◯ Yes, I have approximately ____ drink(s) per day.

Recreational Drug Use: ◯ No ◯ Yes

Tobacco History: ◯ Current Smoker

◯ Never Smoked I Smoke ____ packs per day for _____ years

◯ Former Smoker Tobacco use (please check all that apply)

Age Quit _____ ◯ Cigarettes ◯ Pipe ◉ Cigars ◯ Chewing Tobacco ◯ Vape

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Review of Systems: (Please circle all that apply)

General
Anorexia
Appetite Loss
Chills
Dietary Changes
Fatigue
Fever
Medication Changes
Night Sweats
Obesity
Weight Gain > 10 lbs.
Weight Loss > 10 lbs.
No Symptoms

Skin
Bruising
Change in Wart/Mole
Dryness
Clamminess
Excessive Sweating
Hair Growth
Hair Loss
Hives
Nail Changes
New Lesions
Pruritus *(Itching)*
Pallor *(Abnormal Paleness)*
Rash
Skin Color Changes
No Symptoms

HEENT
Blurred Vision
Headache
Head Injury
Color Blindness
Decreased Night Vision
Diplopia *(Double Vision)*
Excessive Tearing
Eye Pain
Eye Redness
Visual Disturbances
Visual Loss
Hearing Loss
Deafness
Decreased Hearing
Ear Discharge
Ear Infection
Earache
Tinnitus *(Ringing in the Ears)*
Vertigo *(Spinning Sensation)*
Frequent Colds
Nasal Congestion
Rhinitis *(Nasal Discharge)*
Seasonal Allergies
Sinus Pain
Bleeding Gums
Hoarseness
Oral Ulcers
Sore Throat
Voice Changes
No Symptoms

Neck
Neck Mass
Neck Pain
Neck Stiffness
Swollen Glands
No Symptoms

Respiratory
Chronic Cough
Cough
Decreased Exercise Tolerance
Snoring
Difficulty Breathing
Dyspnea *(Shortness of Breath)*
Hemoptysis *(Coughing Blood)*
Sputum Production
Wheezing
No Symptoms

Cardiovascular
Chest Pain
Claudications *(Calf Cramps)*
Difficulty Breathing w/ Exertion
Fainting/Blacking Out
Edema
Irregular Heart Beat
Abnormal Blood Pressure
Hypertension *(Elevated Blood Pressure)*
Orthopnea *(Difficulty Breathing Lying Down)*
Palpitations *(Rapid Heart Rate)*
Paroxysmal Nocturnal Dyspnea *(Difficulty Breathing at Night)*
Leg Pain and/or Swelling
Phlebitis *(Inflammation of the vein)*
Shortness of Breath
Swelling of Extremities
No Symptoms

Gastrointestinal
Abdominal Mass
Abdominal Pain
Black, Tarry Stool
Bloody Stool
Change in Bowel Habits
Constipation
Diarrhea
Dysphagia *(Difficulty Swallowing)*
Food Intolerance
Gas
Hematemesis *(Vomiting Blood)*
Heartburn
Indigestion
Jaundice
Melena *(Abnormal Dark/Tarry Stool Containing Blood)*
Nausea
Rectal Bleeding
Vomiting
No Symptoms

Female Genitourinary
Amenorrhea *(No Menstrual Period)*
Blood in Urine
Change in Bladder Habits
Change in Urinary System
Dsymenorrhea *(Painful Menstruation)*
Dyspareunia *(Painful Intercourse)*
Dysuria *(Difficulty in Urination)*
Metrorrhagia *(Excessive Non-Menstrual Bleeding)*

Female Genitourinary (cont)
Fetal Movements Present
Fetal Movements Decreased
Flank Pain
Hematuria *(Blood in Urine)*
Incontinence *(Inability to Control Urination)*
Menorrhagia *(Excessive Menstrual Bleeding)*
Menstrual Irregularities
Nocturia *(Urination at Night)*
Painful Urination
Pelvic Pain
Polyuria *(Frequent Urination)*
Urethral Discharge
Urgency
Urinary Retention
Vaginal Bleeding
Vaginal Discharge
No Symptoms

Male Genitourinary
Change in Bladder Habits
Change in Urinary System
Dysuria *(Difficulty in Urination)*
Flank Pain
Hematuria *(Blood in Urine)*
Hesitancy of Urination
Impotence
Incontinence *(Inability to Control Urination)*
Nocturia *(Urination at Night)*
Painful Urination
Penile Lesions
Polyuria *(Frequency of Urination)*
Testicular Pain or Mass
Urethral Discharge
Urgency
Urinary Retention
No Symptoms

Musculoskeletal
Backache
Back Pain
Decreased Range of Motion
Fasciculations *(Muscle Twitching)*
Joint Pain/Stiffness/Swelling
Muscle Atrophy *(Weakness)*
Muscle Cramps
Muscle Pain
Myalgia *(Diffuse Muscle Pain)*
Swelling of Extremities
No Symptoms

Neurological
Auras *(Signals Migraine/Seizure)*
Decreased Memory
Difficulty Speaking
Dizziness
Dysarthria *(Difficulty Pronouncing Words)*
Dysesthesia *(Alteration in Sensation)*
Fainting
Focal Neurological Symptoms *(Weakness or Paralysis)*

Neurological (continued)
Headaches
Incontinence Stool
Incontinence Urine
Lack of Coordination
Parasthesias *(Tingling Sensation)*
Syncope *(Loss of Consciousness)*
Vertigo *(Spinning Sensation)*
Stroke
Seizures
Tremor
Unusual Sensation
Unsteadiness
Visual Changes
Weakness
Weakness in Extremities
No Symptoms

Psychiatric
Anxiety
Change in Sleep Pattern
Delusions
Depression
Early Awakening
Fearful
Hallucinations
Hypersomnia *(Excessive Sleeping)*
Inability to Concentrate
Mood Changes
Insomnia *(Inability to Sleep)*
Panic Attacks
Suicidal Ideation
Suicidal Planning
No Symptoms

Endocrine
Appetite Changes
Cold Intolerance
Hair Changes
Heat Intolerance
Hot Flashes
Libido Change
Sexual Dysfunction
Thyroid Problems
Polydipsia *(Excessive Thirst)*
Polyuria *(Excessive Urination)*
No Symptoms

Hematology
Abnormal Bleeding
Anemia
Blood Clots
Easy Bruising
Enlarged Lymph Nodes
Epistaxis *(Nose Bleed)*
Petechiae *(Pinpoint Hemorrhages)*
Prolonged Bleeding
Spontaneous Bleeding
HIV/AIDS
Cancer:_____
No Symptoms

Other Not Listed:
_____

DATE: _____ PATIENT SIGNATURE: _____