A D V A N C E D L I P I D O L O G Y

Please print clearly and complete all information

Name: _____ Date: _____

Date of Birth: _____ Age: _____ SS#: _____

Sex: (check one) ☐ M ☐ F Marital Status: (check one) ☐ S ☐ M ☐ D ☐ W ☐ Sep

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell #: _____

Email Address: _____

Employer: _____

Employer Address: _____

Work Phone: _____ Extension: _____

Preferred method of contact: (check all that apply)

☐ Home # ☐ Cell # ☐ Work # ☐ Email ☐ Letter ☐ Other: _____

Responsible Party/Primary Insured's Name: Please check if same as above ☐

Responsible Party/Primary Insured's Date of Birth: _____

Address (if different): _____

Phone #: _____ Cell #: _____

Relationship to patient: (check one) ☐ Self ☐ Spouse ☐ Dependent ☐ Guardian

Employer: _____

Employer Address: _____

Work Phone: _____ Extension: _____

Emergency Contact: _____

Emergency Contact Phone #: _____

Referring Doctor: _____

Address: _____ Phone: _____

Primary Physician: _____

Address: _____ Phone: _____

Other Physician Contact: (i.e. OB, Cardiologist, etc.) _____

Address: _____ Phone: _____

INSURANCE INFORMATION

This section does not need to be filled out if you provide a copy of your current insurance card

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____

ID#: _____ Group #: _____

Group Name: _____

ADVANCED LIPIDOLOGY – NEW PATIENT HISTORY FORM

Date Completed:

Name *(Last, First, MI.):*		**DOB:**
Preferred Name:	**Home #:**	**Cell #:**

Gender: ☐ Male ☐ Female ☐ Transgender- Male to Female ☐ Transgender- Female to Male ☐ Unsure ☐ Other (Please explain)

Reason for Visit:

Current Medications:

Name of Medication	Dosage	Frequency Taken

MEDICAL CONDITIONS (CURRENT & PAST)

ADD/ADHD	☐ Yes	☐No	High Cholesterol	☐ Yes	☐No
Anxiety	☐ Yes	☐No	Kidney Disease	☐ Yes	☐No
Blood Clots	☐ Yes	☐No	Liver Disease, Hepatitis or Tumor	☐ Yes	☐No
Bleeding Disorder	☐ Yes	☐No	Lupus	☐ Yes	☐No
Cancer	☐ Yes	☐No	Migraine Headache	☐ Yes	☐No
Depression	☐ Yes	☐No	Without Aura	☐ Yes	☐No
Diabetes ☐ Type I ☐ Type II			With Aura (visual changes, lights, numbness)		
Eating Disorder	☐ Yes	☐No	Seizures	☐ Yes	☐No
Anorexia	☐ Yes	☐No	Thyroid	☐ Yes	☐No
Bulimia	☐ Yes	☐No	Tuberculosis	☐ Yes	☐No
Heart Disease or Condition	☐ Yes	☐No	UTI (frequent)	☐ Yes	☐No
High Blood Pressure	☐ Yes	☐No	Stroke or Stroke-like Problems	☐ Yes	☐No

ALLERGIES

Allergies/Intolerance to medications		**Allergies to Food/Insects/Latex**	
Medication	Reaction(s)	Substance	Reaction(s)

SURGICAL HISTORY

Date	Operation	Hospital

HOSPITALIZATIONS

Date	Reason	Hospital

FAMILY HISTORY

Do you have a parent, brother or sister with a history of the following: (if so, **please list relation**)

☐ *** No known Medical problems in family***

	Relation		**Relation**		**Relation**
☐ Anxiety		☐ Heart attack before age 65 in a female		☐ Other cancer	
☐ Asthma		☐ Heart attack before age 55 in a male		☐ Stroke	
☐ Bleeding		☐ High blood pressure		☐ Thyroid Disease	
☐ Depression		☐ High cholesterol		☐ Blood Clot or other clotting disorder	
☐ Diabetes Type II		☐ Skin cancer		☐ Other	

SOCIAL HISTORY

Do you drink alcohol? ☐ No If no, skip next section

How often do you have a drink containing alcohol? ☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many drinks do you typically have when drinking? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion? ☐ Never ☐ Monthly or less ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Has alcohol ever affected your sexual health? ☐ Yes ☐ No

Have you ever experienced a blackout due to alcohol? ☐ Yes ☐ No

Do you use tobacco? ☐ No If no, skip next section

☐ Yes # of Years ☐ Cigarettes – #/day ☐ Chew - #/day ☐ Vaping - #/day ☐ Cigars - #/day

Year quit ☐ Have you quit more than once

Planning to quit: ☐ now ☐ considering quitting ☐ no plan to quit

Do you use recreational drugs? ☐ No (If no, skip this section) ☐ Marijuana ☐ Cocaine ☐ Stimulants ☐ Ecstasy ☐ Opiate Pain Medication (Percocet, Oxy) ☐ Heroin ☐ Hallucinogens (LSD, Mushrooms, PCP) ☐ Other :

EXERCISE

Do you exercise regularly? ☐No ☐Yes Any limiting factors? ☐No ☐Yes – Explain:

Activities:

Days per week: ☐ 1-2 ☐ 3-4 ☐ 5 ☐ 6 ☐7 Duration (minutes): ☐ <15 ☐ 15-30 ☐ 30-45 ☐ 45-60 ☐>60

Exertion: ☐ Mild ☐ Moderate ☐ Heavy

REVIEW OF SYSTEMS (CHECK CURRENT SYMPTOMS ONLY)

General:	☐ Fatigue	**Gastroenterology:**	☐ Nausea	**Neuro:**	☐ Headache
	☐ Fever		☐ Vomit		☐ Numbness
	☐ Chills		☐ Diarrhea		☐ Tingling
	☐ Weakness		☐ Constipation		☐ Spinning sensation
	☐ Weight Changes		☐ Blood in stool		☐ Seizure
	☐ Night Sweats		☐ Abdominal Pain		☐ Loss of consciousness
Heart:	☐ Chest Pain		☐ Heartburn		☐ Fainting
	☐ Irregular heartbeat		☐ Pain		☐ Memory Loss
	☐ Shortness or tightness of breath	**Breast:**	☐ Nipple discharge		☐ Tremor
	☐ Lightheaded		☐ Lump	**Psych:**	☐ Depressed/Low mood
	☐ Leg swelling		☐ Skin changes		☐ Anxiety
	☐ Fainting	**Genital:**	☐ Unusual vaginal bleeding		☐ Sleep problem
Skin:	☐ Rash		☐ Unusual vaginal discharge		☐ Suicidal thinking
	☐ Change in mole		☐ Problems with orgasm		☐ Thoughts of hurting self
	☐ Lump		☐ Painful sex or sexual problems		☐ Cutting
	☐ Dry skin		☐ Unusual bumps or sores		☐ Thoughts of harming others
	☐ Itching		☐ problem with erections		☐ Hallucinations
Endocrine:	☐ Cold tolerance		☐ problem with ejaculation		☐ Paranoia
	☐ Heat tolerance	**Blood/Lymphatic:**	☐ Excessive bleeding	**Respiratory:**	☐ Wheezing
	☐ Increased thirst		☐ Swollen lymph nodes		☐ Chest tightness
	☐ Increased urination	**Muscle:**	☐ Joint pain		☐ Difficulty breathing
Ears/Nose/Throat:	☐ Ear pain		☐ Joint swelling	**Allergy:**	☐ Runny nose
	☐ Ringing		☐ Bruising		☐ Itchy eyes
	☐ Hearing changes		☐ Muscle pain		☐ Sneezing
	☐ Congestion	**Eyes:**	☐ Decreased vision		☐ Food allergy
	☐ Trouble swallowing		☐ Double vision		☐ Insect Allergy
	☐ Hoarseness		☐ Eye pain	**Urinary:**	☐Urinating frequently
			☐ Light sensitive		☐ Urgency
					☐ Pain when urinating
					☐ Blood in urine
					☐ Leaking urine