Dr. Cheryl A. Tarateta
(508) 723-4494
cheryl.tarateta@gmail.com

PATIENT NAME: _____ CASE NO. _____
DATE OF BIRTH: _____
DATE: _____

Do you have vertigo (dizziness)?	Yes _____	No _____
Do you pass out easily (faint or loss of consciousness)?	Yes _____	No _____
Do you have double vision or have you lost sight in one eye?	Yes _____	No _____
Do you have any slurred speech or difficulty with speech?	Yes _____	No _____
Do you have indigestion or difficulty swallowing?	Yes _____	No _____
Do you have any difficulty walking, with coordination or falling to one side?	Yes _____	No _____
Do you have nausea or vomiting?	Yes _____	No _____
Do you have numbness on one side of your face or body?	Yes _____	No _____
Do you have any visual disturbances or rapid eye movement?	Yes _____	No _____
Do you have or have you ever had difficulty in arranging words properly?	Yes _____	No _____
Do you have a headache or head pain that is unlike any you have had before?	Yes _____	No _____
Do you have headaches for hours or days?	Yes _____	No _____
Do you have a history of stroke in your family?	Yes _____	No _____
Do you have chest pain?	Yes _____	No _____
Do you have any change in bowel or bladder habits?	Yes _____	No _____
Do you have a sore that does not heal?	Yes _____	No _____
Do you have any unusual bleeding or discharge?	Yes _____	No _____
Do you have any thickening in your breasts or elsewhere?	Yes _____	No _____
Do you have a change in any wart or mole?	Yes _____	No _____
Do you have a nagging cough or hoarseness?	Yes _____	No _____
Do you have night sweats?	Yes _____	No _____
Do you have pain in neck, jaw or face?	Yes _____	No _____
Do you have a drooping eyelid or change in your pupils?	Yes _____	No _____
Do you have any ringing in your ears?	Yes _____	No _____
Do you take birth control pills?	Yes _____	No _____

What prescription medication are you taking if any?

[ ] High blood pressure medication
[ ] Blood thinners
[ ] Herb, vitamins, or over the counter products
[ ] Other _____

_____

Have you ever had cancer? Yes ____ No ____
Does you pain ever wake you from a sound sleep? Yes ____ No ____
Are you losing weight now without trying? Yes ____ No ____
Are you coughing up blood or noticing it in your stools or urine? Yes ____ No ____
Have you had any loss of bladder or bowel control? Yes ____ No ____
Have you lost consciousness or had double vision recently? Yes ____ No ____
Are you seeing any other doctor now for any reason? Yes ____ No ____
Note: _____
Are you taking any medication or over-the-counter drugs? Yes ____ No ____
Please indicate type (aspirin, etc.) _____
Are you taking herbs, nutriceuticals, botanicals, or vitamins?
Please list _____
What was the date of onset of your last menses? _____

Social History

SMOKER _____ Yes or _____ No, If Yes, how many packs _____
ALCOHOL _____ Yes or _____ No, If Yes, how much _____

Family History

Did you mother or father have any of the following:
Put an **M** for mother, **F** for father, and **B** for both.

( ) High Blood Pressure
( ) Heart Attack
( ) Emphysema
( ) Seizure-Convulsions
( ) HIV Positive
( ) Asthma
( ) Diabetes
( ) Kidney Disease
( ) Ulcer or Stomach Problems
( ) Stroke (Please indicate age when stroke occurred, Mother _____ Father _____)
( ) Arthritis-Rheumatism
( ) Mental Illness
( ) Thyroid Disease
( ) Circulation Problems
( ) Cancer

Comments: _____