

HISTORY & PHYSICAL

DATE _____

Formedic

NAME _____	MARITAL STATUS M S M W D SEP	DATE OF BIRTH _____
ADDRESS _____	PHONE (H) _____	(O) _____
OCCUPATION/ EMPLOYER _____	INSURANCE _____	

FAMILY HISTORY IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Hay fever	11) Arthritis	16) Hepatitis
2) Migraine	7) Asthma	12) Heart disease	17) Cancer
3) Glaucoma	8) Anemia	13) Stroke	18) Depression
4) Diabetes	9) Bleeding disorder	14) Hypertension	19) Alcoholism
5) Thyroid disease	10) Osteoporosis	15) Lipid disorder	20) Mental illness

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
<i>not including pregnancies</i>				

LIST ALL MEDICATIONS YOU ARE NOW TAKING	ALLERGIES	VACCINE	YEAR OF LAST	TEST / EXAM	YEAR OF LAST
		Tetanus / Td		Rectal / Stool	
		Influenza (flu)		Cholesterol	
		Hepatitis		Eye	
		Tuberculosis		Dental	
	SUPPLEMENTS				

MEDICAL HISTORY MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEM

<input type="checkbox"/> Hearing problems <input type="checkbox"/> Ringing in ear <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells <input type="checkbox"/> Vision problems <input type="checkbox"/> Eye pain <input type="checkbox"/> Nose bleeds - recurrent <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Sore throats - frequent <input type="checkbox"/> Hoarseness - prolonged <input type="checkbox"/> Hayfever / Allergies <input type="checkbox"/> Pneumonia / Pleurisy <input type="checkbox"/> Bronchitis / Chronic cough <input type="checkbox"/> Asthma / Wheezing <input type="checkbox"/> Shortness of breath: <input type="checkbox"/> on exertion <input type="checkbox"/> lying flat <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur <input type="checkbox"/> Swollen ankles <input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations <input type="checkbox"/> Leg pain <input type="checkbox"/> Cold numb feet <input type="checkbox"/> Varicose veins / Phlebitis <input type="checkbox"/> Appetite <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> loss <input type="checkbox"/> gain	<input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Gallbladder dis <input type="checkbox"/> Abdominal pain- chronic <input type="checkbox"/> Jaundice / Hepatitis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis <input type="checkbox"/> Bloody or tarry stools <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia Urination - Overactive bladder <input type="checkbox"/> Overnight > than twice <input type="checkbox"/> More than 8 times / 24 hrs. <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> with leakage <input type="checkbox"/> Decrease in force/flow <input type="checkbox"/> Painful <input type="checkbox"/> Stress incontinence-urine leakage with exercise / movement <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Urine infections <input type="checkbox"/> Prostate prob <input type="checkbox"/> Bed wetting <input type="checkbox"/> Weight-loss <input type="checkbox"/> gain <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily <input type="checkbox"/> Cancer <input type="checkbox"/> Fatigue / loss of energy <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Arthritis / Rheumatism <input type="checkbox"/> Back pain <input type="checkbox"/> Bone fracture / joint injury <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Gout <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tremor/hands <input type="checkbox"/> Numbness <input type="checkbox"/> Headaches <input type="checkbox"/> Memory loss <input type="checkbox"/> Depression <input type="checkbox"/> Decreased life enjoyment <input type="checkbox"/> Decreased work performance <input type="checkbox"/> Sleep problems for how long _____ how often _____ sleeping - <input type="checkbox"/> too little <input type="checkbox"/> too much <input type="checkbox"/> waking refreshed <input type="checkbox"/> Concentration problems <input type="checkbox"/> Thoughts of - death <input type="checkbox"/> suicide <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood swings <input type="checkbox"/> Phobias <input type="checkbox"/> Vague aches and pains <input type="checkbox"/> Mental illness <input type="checkbox"/> Sexual problems / enjoyment <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Measles <input type="checkbox"/> Chicken pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> German measles <input type="checkbox"/> Herpes <input type="checkbox"/> Aids / HIV <input type="checkbox"/> STD <input type="checkbox"/> Alcohol _____ oz. per week <input type="checkbox"/> Coffee / Tea _____ cups per day <input type="checkbox"/> Smoking- cig/day _____ # years year quit _____ <input type="checkbox"/> Hair loss: <input type="checkbox"/> Progressive <input type="checkbox"/> Recent <input type="checkbox"/> Exercise _____ <input type="checkbox"/> Street Drugs _____
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FEMALES - Please complete

Menstrual flow:
 Reg. Irreg. Pain / Cramps
 Days of flow _____ Length of cycle _____
 Date -1st day of last period _____

Pain / Bleeding during or after sex

Number of:
 Pregnancies _____ Abortions _____
 Miscarriages _____ Live births _____

Birth control method _____

Flushing / Menopause

Date of last PAP test _____
 Normal Abnormal

Date of last mammogram _____
 Normal Abnormal

SYNOPSIS

In appropriate patients, as an adjunct to diet when diet alone is not enough.

Strike first with VYTORIN vs simvastatin for superior LDL-C efficacy

VYTORIN is indicated as adjunctive therapy to diet for the reduction of elevated TOTAL-C, LDL-C, Apo B, TG, and non-HDL-C and to increase HDL-C in patients with primary (familial and nonfamilial) hypercholesterolemia or mixed hyperlipidemia when diet alone is not enough.

Contraindications: hypersensitivity to any component of this medication; active liver disease; unexplained persistent elevations of serum transaminases; and women who are pregnant, nursing, or may become pregnant.

No incremental benefit of VYTORIN on cardiovascular morbidity and mortality over and above that demonstrated for simvastatin has been established.

SELECTED CAUTIONARY INFORMATION

Skeletal Muscle: Myopathy sometimes takes the form of rhabdomyolysis with or without acute renal failure secondary to myoglobinuria, and rare fatalities have occurred. The risk of myopathy/rhabdomyolysis is dose related. Tell patients to promptly report muscle pain, tenderness, or weakness. Discontinue drug if myopathy is suspected or CK levels rise markedly. Please read additional cautionary information on reverse side.

