Patient Medical History

Confidential

Patient Name_____ Today's Date_____

Date of Birth_____Age_____SSN_____

Height_____ Weight_____ Emergency Contact _____

E-mail Address:_____

Referring Doctor_____ Family Physician _____

Chief Complaint _____

(Reason for today's visit)

Current Medications **Dose** **Frequency**

_____

_____

_____

_____

_____

_____

_____

Have you taken any aspirin, ibuprofen or arthritis medicine in the last two weeks?_____
If so when?_____ Do you bruise easily? _____

DRUG ALLERGIES: _____

Medical Illnesses:

_____

_____

_____

_____

_____

_____

Hospitalizations **Date**

_____

_____

_____

_____

_____

Surgical Procedures **Date**

_____
_____
_____
_____
_____
_____

Have you ever had problems with anesthesia? __Yes __No
If yes, describe:_____

Release of Records

Who may have access to your medical records?

Name **Relation** **Contact Information**

_____
_____
_____
_____
_____

Family History

Family Member	**Medical Illnesses**
Mother	_____
Grandparents (maternal)	_____
Father	_____
Grandparents (paternal)	_____
Sister(s) / Brother (s)	_____

Social History

Are you presently working or going to school full or part time? _____

Employer / School: _____

Marital Status:_____ Do you live alone? _____ Who lives with you?_____

Do you have children?_____ If yes, how many?_____

Do you smoke? __Yes __No Cigars?_____ Pipe?_____ Chewing tobacco?_____

Cigarettes per day?_____ How long have you been chewing or smoking _____

Do you drink alcohol? __Yes __ No
Is it __Social __Heavy __Prior addiction?

Do you take or have you taken recreational drugs? __Yes __No __Prior addiction

Do you have any difficulty sleeping?
__Never __Often __Sometimes __Getting to sleep __Staying awake

Does anyone complain that you snore? __Yes __ No

Do you stop breathing at night? __Yes __No

Do you wake up tired in the morning? __Yes __ No

Do you fall asleep in the daytime? __Yes __No

Caffeine intake: _____ per day

Do you exercise? __ Yes __No Type/Frequency:_____

Are you at risk for AIDS? If yes, explain _____

Review of Systems

Are you currently having, or have you had problems with: (check all that apply)

General well-being
__ Fever
__ Weight loss (>10#)
__ Excess fatigue
__ Recurrent Nausea / vomit
__ Night sweats

Eyes
__ Wear glasses
Date of last exam _____
__ Infections
__ Injuries
__ Glaucoma
__ Cataracts
__ Blurred vision
__ Trouble focusing
__ Recent change in vision

Ears, Nose, Mouth and Throat
__ Wear hearing aids
Date of last exam_____
__ Hearing loss
__ Ear infection
__ Pressure in ears
__ Ringing in ears
__ Pain in ears
__ Balance disturbance
__ Itching in ears
__ Dizziness
__ Nasal congestion
__ Nasal drainage
__ Nosebleeds
__ Sinus problems
__ Sinus infections
__ Sinus headaches
__ Throat infections
__ Difficulty swallowing
__ Lip or mouth sores
__ Sore throats

Respiratory
__ Chronic cough
__ Emphysema
__ Bronchitis
__ Asthma
__ Chronic obstruction
__ Pulmonary disease
__ Shortness of breath
__ Oxygen use at home
__ Pneumonia
__ Lung cancer
__ Tuberculosis
__ Blood in saliva
Date of last chest X-ray_____

Cardiovascular
__ Chest pain
Date of last EKG _____
__ Heart attack
__ High blood pressure
__ Low blood pressure
__ Irregular heartbeat
__ Heart murmur
__ Arm and leg swelling
__ High cholesterol

Gastrointestinal
__ Blood in vomit
__ Indigestion
__ Nausea / vomiting
__ Jaundice
__ Abdominal pain
__ Change in bowel habits
__ Ulcers or Gastritis
__ Colon, liver, stomach cancer
__ Hepatitis

Hematologic
__ Anemia
__ Hemophilia
__ Easy bleeding / bruising
__ Swollen glands

Genitourinary
__ Urinary tract infection
__ Painful urination
__ Blood in urine
__ Difficulty urinating
__ Incontinence
__ Kidney stones
__ Prostate cancer
__ Endometriosis
__ Uterine, ovarian or cervical cancer

Neurological
__ Disorientation
__ Fainting / blacking out
__ Light headedness
__ Seizures
__ Stroke
__ Mini-stroke
__ Memory problems
__ Concentration problems
__ Speech problems
__ Facial weakness/ spasms
__ Muscle weakness
__ Coordination problems
__ Uncontrolled shaking
__ Headache
__ Migraine

Endocrine
__ Diabetes
__ Hormone problems
__ Low blood sugar
__ Thyroid disease
__ Increased appetite
__ Excessive thirst
__ Excessive urination
__ Temperature intolerance
__ Pituitary gland problems
__ Bleeding tendencies

Immunologic
__ Environmental allergies
__ Hay fever
__ Food allergies
__ Immune system problems
__ Connective tissue disease
__ Frequent colds / infections

Skin
__ Eczema or psoriasis
__ Dermatitis
__ Dry or scaling skin
__ Rashes
__ Changes in skin color
__ Changes in moles
__ Skin cancer
__ Breast pain or swelling
Date of last Mammogram _____

Musculoskeletal
__ Broken bones
list:_____
__ Arm or leg weakness
__ Joint pain or swelling
__ Back pain
__ Arthritis

Psychiatric
__ Anxiety
__ Depression
__ Manic/Depression
__ Schizophrenia
__ Considering suicide / homicide
__ Panic attacks
__ Sudden mood swings
__ Emotional difficulties
__ Insomnia
__ Other psychiatric problems
__ Under psychiatric care
__ Desiring psychiatric care

The above information is accurate to the best of my knowledge.

_____ _____
Patient Signature *Date*

I have reviewed the above information with the patient.

_____ _____
Boris Karanfilov, M.D. / Sumit Bapna, M.D. *Date*