

PERSONAL MEDICAL HISTORY

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Note: This is a confidential report of your medical history. Information contained here will be released only if you have authorized us to do so.

NAME _____

DATE _____

BIRTHDATE _____

BIRTHPLACE _____

OCCUPATION _____

PREVIOUS OCCUPATION _____

MARITAL STATUS _____

EDUCATION: YEARS ___HIGH SCHOOL ___COLLEGE ___

WHO REFERRED YOU TO OUR OFFICE? _____

FAMILY MEDICAL HISTORY

Are your parents living? Yes No
How many brothers & sisters do you have?
How many children do you have?
Has any relative ever had:
Heart trouble
Cancer
Tuberculosis
Diabetes
High blood pressure
Stroke
Mental illness
Asthma
Thyroid disease / Goiter
Kidney disease
Stomach ulcers
Other Glandular disease

PERSONAL PAST MEDICAL HISTORY

IMMUNIZATIONS: Have you had:
Pneumonia vaccine - Date
Influenza vaccine - Date
Tetanus shot - Date
Measles & Mumps vaccine - Date
Please list all medications you are currently taking, including over-the-counter and herbal medications.

Would you rate your general health as:
Good Fair Poor
Do you use tobacco products?
Cigarettes: # per day Pipe Cigars
How long have you been smoking: years
Do you chew tobacco?
Check if you regularly drink:
Hard Liquor 1-3 oz. per day Over 3 oz. per day
Beer 1 bottle per day 2 bottles 3 or more
Wine 1 glass per day 2 glasses 3 or more
Do you drink coffee?
Do you ever use illicit drugs?
Do you exercise regularly?
Do you wear glasses/contact lenses?
When was your last eye exam?

SURGERY AND HOSPITALIZATIONS

Have you ever had surgery? Yes No
If yes, please list:
Type Year
Type Year
Type Year
Have you ever been advised to have any operation which has not been done? Yes No
Have you ever been hospitalized? Yes No
If yes, please list:
Reason Year
Reason Year
Reason Year

ILLNESSES

Have you ever had:
Kidney stones / disease
Angina pectoris
Other heart disease
Gallbladder disease
Frequent kidney / bladder infection
Migraine headaches
Osteoporosis
Bone disease
Measles
Chicken pox
Rheumatic fever
Tuberculosis
Pneumonia
Asthma or emphysema
Heart attack
Phlebitis
High blood pressure
Thyroid disease
Stomach ulcers
Cancer
Hepatitis or jaundice
Seizures
Meningitis
Depression or mental illness
Anemia
Other endocrine diseases
Any serious injury

REVIEW OF SYSTEMS

Do you now have or have you had (within the past year):

- Change in your weight (more than 10 pounds)..... Yes No
- Heat or cold intolerance Yes No
- Drinking more water or fluids Yes No
- Unusual or chronic fatigue Yes No
- Previous neck irradiation (ever) Yes No
- Change in the color of your skin Yes No
- Unusually dry skin..... Yes No
- Skin rashes or growths that bother you..... Yes No
- Changes in moles Yes No
- Trouble with your vision..... Yes No
- Change in hearing or trouble with your eyes ... Yes No
- Sinus trouble or hay fever Yes No
- Persistent hoarseness Yes No
- Difficulty swallowing Yes No
- Coughed up blood Yes No
- Chronic or frequent cough Yes No
- Shortness of breath Yes No
- Wheezing or difficulty breathing Yes No
- Night sweats Yes No
- Palpitations or fluttering of the heart Yes No
- Pain, tightness, or pressure in your chest Yes No
 - If yes, is it when you're walking fast, working hard or when excited?..... Yes No
- Swelling of feet or ankles Yes No
- Cramps of the calf muscles when you walk or at night? Yes No
- A history of abnormal electrocardiogram (ever)..... Yes No
- Recurrent heartburn or indigestion Yes No
- Recurrent nausea or vomiting Yes No
- Vomited blood..... Yes No
- Frequent loose stool or diarrhea Yes No
- If yes, does it awaken you from sleep? Yes No
- Constipation Yes No
- Blood in bowel movement Yes No
- Recent changes in your bowel habits Yes No
- Pain or burning during urination Yes No
- Increased frequency or amount of urination Yes No
- Waking up at night to urinate Yes No
- If yes, how often? _____
- A problem with dribbling urine Yes No
- Blood in urine..... Yes No
- An operation to prevent pregnancy..... Yes No (i.e. vasectomy, tubal ligation)
- Joint or bone pain or swelling Yes No
- Frequent or severe headaches Yes No
- Double vision Yes No
- Loss of the ability to speak for a few seconds..... Yes No
- Recently fainted / blacked out Yes No
- Loss of consciousness Yes No
- Numbness, tingling or pain in your arms or legs Yes No
- Seizures (convulsions or fits)..... Yes No

ALLERGIES: Are you allergic to:

- Any medications? Yes No
- Any foods? Yes No
- Other?..... Yes No
- If yes, what

What type of reaction did you have? _____

WOMEN ONLY

- Age at first period _____
- Date of last pelvic exam _____
- Date of last PAP test _____
- Do you have any vaginal discharge or irritation?..... Yes No
- How many pregnancies _____
- How many children _____
- Any problems becoming pregnant? Yes No
- Any complications with pregnancy?..... Yes No
- Describe _____
- Are you sexually active?..... Yes No
- Is sex entirely satisfactory?..... Yes No
- If you are still having periods:
 - Are your periods regular? Yes No
 - How often are your periods _____
 - How many days does each last _____
 - Flow: Heavy Medium Light
 - Do you bleed between periods? Yes No
 - Date of last period _____
 - What form of birth control do you use? _____

- Have you had lumps in your breast? Yes No
- Do you perform self breast examination monthly? Yes No
- Is there a family history of breast cancer? Yes No
- Have you had pervious mammograms?..... Yes No
- Do you have nipple discharge? Yes No

If your periods have stopped:

- Age at menopause _____
- Any bleeding since menopause Yes No
- Do you have hot flashes? Yes No
- Are you now or have you in the past been on estrogen replacement therapy? Yes No
- If you had a hysterectomy, were your ovaries removed? Yes No

MEN ONLY

- Do you have any discharge from your penis?..... Yes No
- Do you have any sores on your penis? Yes No
- Has there been any change in the size of your testicles?..... Yes No
- Do you have any difficulty with erections? Yes No
- Is sex entirely satisfactory?..... Yes No
- Have you been told of low sperm count in the past? Yes No
- Date of last prostate exam _____