

HEALTH HISTORY-----Jeff Paley, MD PC Doron Katz, MD PC

(We know this is long and tedious, but it is very helpful to us and ultimately to you!)

Today's date _____

PATIENT NAME _____ BIRTHDATE ____/____/____

This history form provides us with information to help us meet all your healthcare needs. This is a confidential part of your medical record and will be maintained confidentially.

Place of Birth _____

Occupation _____

Previous occupations _____

Marital status _____

Hobbies _____

Exercise/recreation _____

Habits:

Smoking (type & amount per day) _____

If former smoker, date quit _____

Alcohol (type & amount per week) _____

Caffeine (type & amount per day) _____

Usual weight _____ My ideal weight _____

Date of last dental exam _____

Please list all allergies (foods, drugs, environment) _____

When was your last physical exam? _____

Name of doctor _____ Phone _____

When did you last have blood tests done? _____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:

Please list all medicines you are currently taking (include nonprescription drugs, alternative therapies and supplements):

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):

Last Examinations by:

Dermatologist _____ Dentist _____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

1) _____ 3) _____

2) _____ 4) _____

PAST MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Chickenpox no yes

Scarlet Fever no yes

Diphtheria no yes

Pneumonia no yes

Rheumatic no yes

Fever no yes

Tuberculosis no yes

Anemia no yes

Urinary Tract no yes

Infections no yes

Seizure no yes

Glaucoma no yes

Hernia no yes

Transfusion no yes

High Blood Pressure no yes

Mitral Valve Prolapse no yes

Hepatitis no yes

FAMILY HISTORY

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

Relationship			Relationship		
Cancer	no	yes _____	Depression	no	yes _____
Tuberculosis	no	yes _____	Psychosis	no	yes _____
Diabetes	no	yes _____	Suicide	no	yes _____
Heart disease	no	yes _____	Leukemia	no	yes _____
High blood Pressure	no	yes _____	Migraine		
Stroke	no	yes _____	Headaches	no	yes _____
Seizures	no	yes _____	Obesity	no	yes _____
Allergies	no	yes _____	Thyroid		
Anemia	no	yes _____	Disease	no	yes _____
Bleeding Tendency	no	yes _____	Ulcer	no	yes _____
Asthma	no	yes _____	High Cholesterol	no	yes _____
Chronic Lung Disease	no	yes _____	Kidney Disease	no	yes _____
Drug/Alcohol Problem	no	yes _____	Glaucoma	no	yes _____
			Gout	no	yes _____

List the present age or the age of death of each of the following members of your family, also if living add if their health is good, fair, or poor. If deceased, list the cause of death.

Father _____
 Mother _____
 Brother _____

 Sister _____

 Spouse _____

Son _____

 Daughter _____

