

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	Anemia	no	yes	High Blood Pressure		
Scarlet Fever	no	yes	Urinary Tract				no	yes
Diphtheria	no	yes	Infections	no	yes	Mitral Valve Prolapse		
Pneumonia	no	yes	Seizure	no	yes		no	yes
Rheumatic			Glaucoma	no	yes	Hepatitis	no	yes
Fever	no	yes	Hernia	no	yes			
Tuberculosis	no	yes	Transfusion	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 _____

MEDICAL HISTORY cont.

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

Weakness never occasionally often
Tire easily never occasionally often
Weight Change never occasionally often
Change in Appetite never occasionally often
Sensitivity to Cold or heat never occasionally often
Persistent Fever never occasionally often
Night sweats never occasionally often
Hot flashes never occasionally often
Skin problems never occasionally often
Change in nails Or hair never occasionally often
Headaches never occasionally often
Easy bleeding never occasionally often
Easy bruising never occasionally often
Double vision never occasionally often
Blurred vision never occasionally often
Eye pain never occasionally often
Do you wear Glasses or Contacts never occasionally often
Last eye exam _____
Ringing in Ears never occasionally often
Ear pain never occasionally often
Hearing loss never occasionally often
Frequent nose Bleeds never occasionally often
Frequent colds never occasionally often
Sinus problems never occasionally often
Loss of smell never occasionally often
Persistent Hoarseness never occasionally often
Sore throat never occasionally often
Sore gums never occasionally often
Breast lump or Discharge never occasionally often
Chronic cough never occasionally often
Shortness of Breath never occasionally often
Bloody sputum never occasionally often
Wheezing never occasionally often
Chest pain or Discomfort never occasionally often

Purple fingers Or lips never occasionally often
Swelling of hands Feet or ankle never occasionally often
Difficulty Breathing never occasionally often
Palpitations or Fluttering of Heart never occasionally often
Leg cramps never occasionally often
Enlarged veins never occasionally often
Difficulty Swallowing never occasionally often
Heartburn never occasionally often
Frequent Belching never occasionally often
Abdominal Cramping never occasionally often
Nausea never occasionally often
Vomiting never occasionally often
Vomited or Coughed up Blood never occasionally often
Chronic Diarrhea never occasionally often
Chronic Constipation never occasionally often
Rectal bleeding never occasionally often
Black tarry Stools never occasionally often
Dark urine never occasionally often
Yellow jaundice never occasionally often
Frequent (day) Urination never occasionally often
Frequent (night) Urination never occasionally often
Increase in Thirst never occasionally often
Painful Urination never occasionally often
Leakage of Urine never occasionally often
Difficulty Starting Urine never occasionally often
Blood in urine never occasionally often

Lack of sex Drive never occasionally often
Hemorrhoids never occasionally often
Backaches never occasionally often
Joint pain or Stiffness never occasionally often
Swollen joints never occasionally often
Muscle cramps Or spasms never occasionally often
Sleeplessness never occasionally often
Seizures never occasionally often
Depression never occasionally often
Memory loss never occasionally often
Poor Coordination never occasionally often
Dizziness never occasionally often
Fainting never occasionally often
Men only:
Discharge from Penis never occasionally often
Pain or lump In testicles never occasionally often
Impotence never occasionally often
Women only:
Age period began _____
of days period lasts _____
Days between periods _____
Is your flow Heavy? never occasionally often
Date of last period _____
Date of last pap _____
Pain with Intercourse never occasionally often
Do you bleed or spot between periods never occasionally often
Do you have pain or Cramps? never occasionally often
Do you have mood swings or irritability with your period? never occasionally often
Date of last Mammogram _____
Birth Control used: Yes No
Type/Medication _____
Number of pregnancies _____
Number of full term Births _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Signature _____ Date _____

Physician's comment

Physician's Signature _____