PATIENT HISTORY

Patient Name: _____ **Date of Birth**: _____

Primary Physician: _____ **Requested By**:_____

Chief Complaint:_____

Please list your single worst complaint that caused you to come to the doctor

	YES	NO	DATE
Is your condition related to a Motor Vehicle Accident?	__	__	_____
Work Related Injury?	__	__	_____

Medical History: Please check YES or NO for each disease

Yes	No		Yes	No	
__	__	AIDS or HIV+	__	__	Kidney disease
__	__	Arthritis	__	__	Migraine headaches
__	__	Asthma	__	__	Polio
__	__	Cancer (list condition below)	__	__	Rheumatic Fever
__	__	Diabetes	__	__	Stroke
__	__	Epilepsy	__	__	Thyroid disease
__	__	Heart disease (list condition below)	__	__	Tuberculosis
__	__	Hepatitis A B C (circle one)	__	__	Venereal disease
__	__	High blood pressure	__	__	Ulcers

Other: _____

Surgical History: List all surgeries and dates (or year) that surgery was performed.

_____ _____ _____

_____ _____ _____

Allergies: Please check YES or NO for each medication. If yes, please list the reaction you experienced.

Yes	No		Yes	No	
__	__	Antibiotics _____	__	__	Aspirin or Ibuprofen (circle one)
__	__	Morphine, Demerol or other	__	__	Tetanus antitoxin _____
		narcotics _____	__	__	Iodine or other antiseptics_____
__	__	Novocain or anesthetics _____	__	__	Shellfish

Medications: List all medications, the dose (mg/gram etc) and frequency (once a day, ect)

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Social History: Please check: __ Married __ Single __ Divorced __ Widowed # of children _____

Do you, or have you ever smoked cigarettes? __yes __no; if yes, _____ packs/day for _____ years; If you quite, how long ago_____

Do you drink alcohol? __yes __no; if yes, how much-daily ____, weekly____, or monthly ____?

Do you now or have you ever used illicit drugs ? __yes __no; if yes, specify type and frequency. _____

What is your occupation?_____

Patient Name: _____ **Date of Birth**: _____

Family History: Please CIRCLE Current Age/Age at Death Health Conditions and/or cause of death

Father Alive/Dead _____ _____

Mother Alive/Dead _____ _____

Sister and or Bother Alive/Dead _____ _____

Review of systems: Have you had any of the following in the past 6 months**? Please check every line** Yes or No

Constitutional	Yes	No	**Respiratory**	Yes	No	**Neurologic**	Yes	No
Fever	__	__	Cough	__	__	Headaches	__	__
Weight loss	__	__	Short of breath	__	__	Numbness/tingling	__	__
Weakness	__	__	Wheezing	__	__	Memory loss/confusion	__	__
Eyes			**GI**			**Integumentary**		
Double vision	__	__	Nausea/vomiting	__	__	Easy bleeding/bruising	__	__
Blurred vision	__	__	Diarrhea	__	__	Skin rash	__	__
Visual loss / eye pain	__	__	Constipation	__	__	Varicose Veins	__	__
ENT			Blood in stool	__	__	**Endocrine**		
Sore throat	__	__	**GU**			Excessive thirst	__	__
Earache	__	__	Frequent urination	__	__	Cold/heat intolerance	__	__
Hearling loss	__	__	Incontinence	__	__	Decreased sex drive	__	__
Dizzy/vertigo	__	__	Nighttime urination	__	__	**Psychiatric**		
CV			**Musculoskeletal**			Depression	__	__
Chest pain	__	__	Joint pain	__	__	Anxiety	__	__
Palpitations	__	__	Neck pain	__	__	Insomnia	__	__
Swollen ankles	__	__	Back pain	__	__			

Radiologic Studies:

___MRI (date)_____ (performed at) _____

___CT (date) _____ (performed at) _____

To the best of my knowledge, all 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 of any changed in my health status.

_____

** Patient (guardian) Signature ** Date Completed

Notes:_____

_____

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Dr.Signature:_____Date_____

David P. Sachs, M.D. Lloyd Zucker, M.D. Evan Packer, M.D. Martin Greenberg, M.D.