

Gary D. Levinson, M.D. Bryan L. Abramowitz, M.D.

Aristotelis T. Laliotis, M.D.

Name: _____

Age: _____ Date: _____

CONFIDENTIAL MEDICAL HISTORY

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space. Please leave no blanks.

CHIEF COMPLAINT

List the problems which have led you to seek medical help now and approximately when each began:

	Problem	Date of Onset
1		
2		
3		
4		

PAST MEDICAL AND SURGICAL HISTORY

List chronologically all previous medical and surgical illnesses. Indicate the nature of each operation, including hospitalization and where and when it was done.

Operation	Hospital and City	Date

CURRENT MEDICATIONS

List all the medications you are now taking. For each, give the name, the strength of each dose, how often taken, and when you began taking it. This list **MUST** be detailed, accurate, and complete; therefore consult with your family, druggist, physician. (Do not neglect aspirin and pain medicines; hormones; contraceptives, water, diet, nerve or sleeping pills.)

Name of Medicine	Strength of each dose	How often taken	When began taking

Your doctor's name and address _____

Do you want a report sent to him? Yes () No ()

FAMILY HEALTH

Please give the following information about the health of your immediate family:

RELATION	Age if alive	Age at death	State of health or cause of death
Mother			
Father			
Brothers			
& Sisters			

Have any blood relatives ever had any of the following? (If so, indicate relationship.)

Diabetes _____ Cancer _____ Allergies _____
 Migraine _____ Seizures or epilepsy _____ Any obscure or unusual disease _____
 Tuberculosis _____ Blood disease _____ Abnormal bleeding or clotting _____

REVIEW OF SYSTEMS

Answer all questions. If you do not know the answer or do not understand the question, insert a question mark. LEAVE NO BLANKS!

PHYSICIAN'S COMMENTS
(Leave Blank)

	NO	YES ? date of onset
RESPIRATORY		
Have you ever had any of the following? (If so, indicate when.)		
Pneumonia		
Bronchitis		
Emphysema		
Tuberculosis		
Tuberculosis skin test		
Asthma (wheezing)		
Exposure to dangerous dust or fumes		
Abnormal chest x-ray		
Have you ever coughed up blood?		
Do you often cough?		
Do you often get colds?		
Do you smoke cigarettes?		
When was your last chest x-ray?		
CIRCULATORY		
Have you ever had any of the following? (If so, indicate when.)		
Heart murmur		
Heart attack (coronary)		
Angina pectoris		
High Cholesterol		
High blood pressure		
Rheumatic fever		
Severe chest pain		
Heart failure		
Abnormal electrocardiogram		
Normal electrocardiogram		
Swelling of your ankles		
ENDOCRINOLOGY		
Have you ever had any of the following? (If so, indicate when.)		
Thyroid disease		
Diabetes		
DIGESTIVE		
Do you often or regularly have:		
Trouble swallowing		
"Heartburn"		
Food "repeating"		
Nausea or vomiting		
Abdominal pain		
Constipation		
Diarrhea		
Has there been any change in way your bowels function in the last six months?		
Have you lost weight?		
Have you ever had any of the following? (If so, indicate when.)		
Ulcer		
Hiatal or esophagus hernia		
Vomiting of blood		
Black or tarry stools		

Significant
chest pain? _____
claudication? _____
dyspnea? _____

Significant
Abdominal
Pain? _____
Alcoholic Consumption
per day? _____
per week _____

	NO	YES ? date of onset
DIGESTIVE (con't)		
Liver trouble		
Gallbladder trouble or stones		
Persistent diarrhea or colitis		
Diverticulitis		
Blood in your stool		
Do you regularly use a laxative?		
Have you ever had x-rays of your:		
Stomach (GI series)		
Gallbladder		
Bowel (Barium enema)		
URINARY		
Have you ever had or been told you had any of the following? (If so, indicate when.)		
Kidney disease or nephritis		
Protein or albumin in urine		
Blood or pus in urine		
Kidney stones		
Urinary infection		
Prostate trouble		
Syphilis or gonorrhea		
OBSTETRIC & GYNECOLOGICAL		
Have you ever had breast lumps?		
How many times have you been pregnant (including miscarriages)?		
Are you now taking hormones or birth control pills?		
When was your last Pap smear?		
Are your periods regular?		
NEUROLOGICAL		
Have you ever had any of the following? (If so, indicate when.)		
Frequent or recurrent headaches		
Loss of consciousness		
Convulsions or seizures		
Head injury		
Stroke or paralysis		
Double vision		
Deep depression or hopelessness		
Deafness		
Visual impairment		
ALLERGY & IMMUNOLOGY		
Have you ever had:		
Hives		
Rash or other skin problems		
Hay fever or stuffy nose		
A reaction to x-ray dye		
Have you ever had a bad reaction to aspirin, penicillin or any other		