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PATIENT MEDICAL HISTORY

NAME _____ BIRTH DATE _____ DATE _____

HOSPITALIZATIONS: List all medical and surgical admissions, including dental.

<u>Date</u>	<u>Hospital</u>	<u>Operation/Illness</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: If you are allergic to any medications or foods, list them below, along with the type of reaction.

MEDICATIONS: If you are taking any medications, list them along with the amount of each dose and the number of times each day you take it.

<u>Name</u>	<u>Dosage</u>	<u>Times/Day</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HABITS:

Have you smoked? Y N How much per day? _____
 Age started _____ Date quit, _____
 Do you drink alcohol? Y N If yes, how much? _____

HAVE YOU HAD:

	<u>Y/N</u>	<u>Date</u>	<u>Why</u>
CAT scan	___	_____	_____
Ultrasound	___	_____	_____
Transfusion	___	_____	_____

PHYSICIANS you have seen in the last 3 years:

<u>Physician Name</u>	<u>Problem Treated</u>	<u>Last Seen</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: Please circle any diseases that have occurred in your family:

	<u>Diabetes</u>	<u>Cancer</u>	<u>TB</u>	<u>Heart disease</u>	<u>Stroke</u>
Father	___	___	___	___	___
Mother	___	___	___	___	___
Sister	___	___	___	___	___
Brother	___	___	___	___	___

REVIEW OF SYSTEMS

Do you have, or have you had, any of the following:

	<u>Yes</u>	<u>No</u>
Abdominal pain	___	___
Anemia	___	___
Arthritis	___	___
Asthma	___	___
Backaches	___	___
Blood in the urine	___	___
Blurred vision	___	___
Breast biopsy	___	___
Breast lumps	___	___
Breast pain	___	___
Changes in voice	___	___
Chest pain with exertion (angina)	___	___
Colitis	___	___
Coughing up blood	___	___
Diabetes	___	___
Diarrhea	___	___
Epilepsy	___	___
Bleed or bruise easily	___	___
Blood with bowel movements	___	___
Fatigue	___	___
Gallbladder problems	___	___
Glaucoma	___	___
Headaches	___	___
Heart attack	___	___
Heart murmur or other condition	___	___
Heartburn	___	___
Hemorrhoids	___	___
Hepatitis	___	___
Hernia	___	___
High blood pressure (hypertension)	___	___
High cholesterol (blood fat)	___	___
Jaundice	___	___
Kidney stones	___	___
Loss of speech	___	___
Lumps in neck	___	___
Malignancies (cancer)	___	___
Memory difficulties	___	___
Menstrual problems	___	___
Nausea or vomiting	___	___
Nipple discharge	___	___
Pain in the feet	___	___
Pain/cramps in legs when walking	___	___
Radiation treatments	___	___
Sexually transmitted disease	___	___
Shortness of breath	___	___
Stomach ulcers	___	___
Stroke	___	___
Swallowing difficulty	___	___
Swelling in feet or ankles	___	___
Thyroiditis	___	___
Tuberculosis	___	___
Weakness or loss of sensation in any area	___	___
Weight gain or loss recently	___	___

For clinical use only:
Information given: _____
Type: _____