

**PAST MEDICAL, SOCIAL, AND FAMILY HISTORY**

**IDENTIFICATION DATA:** Please PRINT the following information:

Name: \_\_\_\_\_ [ ] Male [ ] Female

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ] Single

EDUCATION : What is the highest level of education you have completed?  
[ ] Elementary School [ ] High School [ ] College, Business School (# of years \_\_\_\_\_)

Do you have any spiritual practices, of which you would like to make us aware, that would impact the medical care plan we would provide to you? \_\_\_\_\_ No \_\_\_\_\_ Yes (If yes, please explain \_\_\_\_\_)

**PRESENT ILLNESS:** What symptoms led you to seek medical care from this office? Please provide extent of illness/problems.

\_\_\_\_\_

**IMPORTANT:** How long have you had this problem/illness? (When did your symptoms start?)

\_\_\_\_\_

Has anyone else treated you for this condition?  
\_\_\_\_\_

**MEDICAL ILLNESSES:** List each illness for which you are currently being treated and the doctor treating you for that illness:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** Important: Please complete attached medication sheet:

**Pharmacy Name & Phone Number:** \_\_\_\_\_

**What is your current weight?** \_\_\_\_\_ **Height?** \_\_\_\_\_

**Do you have any implants?** [ ] yes [ ] no If yes, list \_\_\_\_\_

**Are you allergic to Latex?** [ ] yes [ ] no

**Are you sensitive or allergic to any medications or dyes?** [ ] Yes [ ] No If yes, please list:

\_\_\_\_\_  
\_\_\_\_\_

**NUTRITIONAL ASSESSMENT:**

Have you had a weight gain or loss of greater than 10 lbs. in the last six months? [ ] Yes [ ] No

Do you have any problems eating or any problems swallowing food? [ ] Yes [ ] No

Do you have any special dietary needs the doctor should be aware of? [ ] Yes [ ] No

If yes, explain: \_\_\_\_\_

**PLEASE TURN TO NEXT PAGE TO CONTINUE →**

**MEDICAL HISTORY:** Check all of the following medical problems you have or have had.

<input type="checkbox"/> Heart attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Coronary Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer: _____
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Anemia	<input type="checkbox"/> Lung Disease: _____
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Limb Swelling/Pain	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Weakness	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Chronic cough

Please list any other conditions not mentioned above: \_\_\_\_\_

**SURGICAL HISTORY:** Write in your most recent operations below. Have you had more than 4 operations?  yes  no

	Year	Type of Operation	Name of Hospital	City and State
1 <sup>st</sup> Operation				
2 <sup>nd</sup> Operation				
3 <sup>rd</sup> Operation				
4 <sup>th</sup> Operation				

**FAMILY HISTORY:** For each member of your family, place an x under any disease they have had.

	Deceased? Yes or No	Current Age or Age at Death	Diabetes	Hypertension	Stroke	Heart Disease	Vascular Disease
Father							
Mother							
Brothers/Sisters							

**SOCIAL HISTORY:**

Yes	no		
		Do you drink coffee or tea?	How many cups of tea each day? _____ How many cups of coffee each day? _____
		Do you now or have you ever smoked tobacco?	How old were you when you started?
		**If yes, Have you quit smoking?	How old were you when you quit?
		**If yes, how many cigarettes, cigars, and/or pipes did/do you smoke a day?	# _____ cigarettes per day # _____ cigars per day # _____ pipes per day
		Do you drink beer, wine, or liquor?	How much alcohol do you drink each week? # _____ 12oz glasses of beer # _____ 6 oz glasses of wine # _____ 1 oz glasses of liquor
		Do you or have you had a drug abuse problem?	If yes, describe briefly (drug, duration, extent of problem) _____

Do you have a living will?  yes  no  
 Have you appointed someone as your medical power of attorney?  yes  no  
 Information on Advanced Directives is available upon request at the front desk.

**FOR OFFICE USE ONLY:** I have examined and reviewed this document with the patient.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dale Buchbinder, M.D. David P. Coll, M.D. Jeffrey E. Kremen, M.D. R. Jeffrey Breslin, M.D.