

CURRENT MEDICATIONS:

NAME: DOSE FREQUENCY

1
2
3
4
5
6
7
8
9
10
11

EMAIL ADDRESS: _____@_____

WHAT MEDICATIONS CAN YOU NOT TAKE OR ALLERGIC TO

Please circle or fill in

SOCIAL HISTORY:

advanced directives?	yes	no
alcohol use	none	social frequent
marital status	single	married domestic partner divorced widow
occupation	_____	
tobacco use	yes	no
prior tobacco use	yes, for how long? _____	no

FAMILY HISTORY: (PARENTS, BROTHERS, SISTERS, AUNTS,UNCLES, GRANDPARENTS) IF POSITIVE, NOTE WHO HAS

DIABETES		HEART DISEASE	
CANCER		STROKE	

YOUR OWN SURGICAL HISTORY: (WRITE IN TYPE OF SURGERY AND YEAR)

YOUR PAST MEDICAL HISTORY

CHECK OFF ONLY THE POSITIVES

abnormal pap smear		hernia	
alcohol problems		herpes	
anaphylactic reaction (severe allergies)		hirsutism (excessive hair growth)	
anemia		history of psychiatric problems	
angina		high blood pressure	
anxiety disorder		hypothyroidism (underactive thyroid)	
aortic aneurysm		erection problems	
arthritis conditions		incontinence	
asthma		kidney problems	
birthcontrol pill use		lipid disorders (high cholesterol)	
bladder dysfunction		liver conditions	
bleeding tendencies		lung cancer	
bowel problems		menopause	
breast problems		mental health conditions	
bronchitis		migraines	
cancer/tumors		murmur	
candidiasis (yeast infection)		musculoskeletal problems	
cardiac arrhythmias (irregular heart rhythm)		neurological symptoms or diseases	
cardiac catheterization		neuropathy (painful nerves)	
cardiac disease		nocturia (awakening to urinate > 2)	
cardiomyopathy (weak heart)		obesity	
claudication (leg pain)		osteoporosis	
colon polyps		ovarian conditions	
congestive heart failure		parkinson's disease	
COPD (emphysema)		pelvic inflammatory disease (GYN infections)	
deep vein thrombosis (clot)		peripheral vascular disease (circulation disorder)	
dementia (memory trouble)		phlebitis	
depression		pneumonia	
dermatitis (skin problems)		pneumovax shot, when was your last	___/___
diabetes		prostate conditions	
diverticulitis		pruritis (itching)	
dysmenorrhea (menstrual cramps)		lung blood clot	
ear conditions		renal failure/insufficiency (kidney disease)	
dysphagia (swallowing difficulties)		respiratory condition	
head injury		rheumatoid arthritis	
eczema (allergic skin rash)		sciatica (pinched nerve)	
eye conditions		seizure disorders	
eye exam, most recent when	___/___	sexual problems	
fibromyalgia		sexual abuse	
fibrositis (muscle pain)		shortness of breath	
fracture history		sinusitis	
frequent colds		skin cancer	
frequent ear infections		skin lesions (moles,warts)	
gall bladder problems		sleep apnea	
gastritis		stomach or intestinal problems	
		stroke	
GERD (heartburn)		syncope (blackout)	
GI bleed (intestinal bleeding)		thyroid disorder	
grave's disease (overactive thyroid)		ulcer	
heart valve conditions/replacement		vaginal problems	
hematochezia (stool blood)		varicose veins	
hematuria (urine blood)		weight change (> 5lbs/year)	
hepatitis vaccination			

NAME: _____

DATE: _____

PLEASE SELECT UP TO 10 PROBLEMS YOU HAVE NOW OR RECENTLY HAD

angry feelings		joint pain	
ankle swelling		knee pain	
anxious feelings		leg cramps	
any unusual skin lesions		leg swelling	
appetite decrease		light headedness	
awake too easily		loose stools	
back pain		loss of height	
belly pain		loss of vision	
black bowel movements		low energy	
blackouts or woozy		low mood	
bladder control problems		lumps	
bloating		memory loss	
blood in stool		muscle pain	
breast lump		muscle tenderness	
breathing difficulty		nasal drainage	
bruise easily		nausea	
burning with urination		neck pain	
calf pain		numbness	
change in bowel habits		painful periods	
change in voice		panic attacks	
chest pressure/tightness		pms	
chest symptoms		post nasal drip	
constipation		psychiatric or emotional difficulties	
cough		rape or sexual abuse victim	
daytime drowsiness		recreational drugs	
depression		regurgitation	
difficulty sleeping		sciatica	
difficulty with swallowing		seasonal allergies	
dizziness		shortness of breath	
dry skin		sinus congestion	
ear wax		skin problems	
enlarged goiter		sleep problems	
enlarged or tender glands		snoring	
erection problems		sores or lumps in penis, testicle	
extreme highs and lows		stiffness	
eye pain		stress	
eye/vision problems		sweats	
face pain		tingling	
feelings of hopelessness		trouble concentrating	
fever		uncomfortable urination	
foot pain		unusual tiredness	
forgetfulness		urinary hesitancy	
frequent back pain		urinary incontinence	
frequent colds		urinary urgency	
hair loss		urinate frequently at night	
head allergy symptoms		urinating too often	
headache		vision problems	
hearing loss		vomiting	
heart palpitations		water retention	
heartburn		weakness	
heel pain		weight change	
hip pain		weight loss, unintentional	
hot flashes		wheezing	
irritability			

Josh Schwartzberg D.O.

877-DOCJOSH