

PATIENT HISTORY

CONFIDENTIAL INFORMATION: Medical information will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge. The information you provide will be used by your doctor to make decisions regarding your care.

NAME (First, Middle initial, Last) _____ AGE _____ HT _____ WT _____

REASON FOR VISIT _____ DATE ____/____/____

REFERRAL SOURCE _____ PRIMARY CARE PHYSICIAN _____

SURGERY: LIST THE NAMES AND YEAR OF **ANY** OPERATIONS YOU HAVE HAD (including cosmetic surgery).

MEDICAL CONDITIONS (List all):

MEDICATION: LIST ALL CURRENT MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER). BE SURE TO INCLUDE TYLENOL, ASPIRIN, IBUPROFEN, BLOOD PRESSURE PILLS, BLOOD THINNING PILLS, STEROIDS, INSULIN, **AND ANY DIET PILLS.**

LIST ALL DRUG ALLERGIES & REACTIONS: _____

DO YOU HAVE OR HAVE YOU EVER HAD: (Please circle all that apply)

- CONSTITUTIONAL: unexplained fever or chills / weight loss or gain / headaches or migraine
- EYES: double, blurry vision / dry eyes / other visual problem with one or both eyes
- EARS, NOSE, MOUTH, THROAT: hearing problems / nose bleed / sore throat / lump in neck
- HEMATOLOGIC/ LYMPHATIC: blood clot / blood transfusion / hepatitis / bleeding or bruising tendency / HIV or AIDS / enlarged lymph node / Lymphoma / Hodgkin's disease / spleen removal
- GI: liver disease / hepatitis / gallstones / irritable bowel / stomach ulcers, gastritis, heartburn / constipation diarrhea / hemorrhoids / blood in stool / fecal incontinence
- CANCER (type & treatment): _____
- CIRCULATORY/ HEART: high blood pressure/ chest pain / congestive heart failure / heart attack / mitral valve prolapse / heart abnormality / irregular heart beat / heart murmurs / palpitation / blood vessel disease / peripheral vascular disease (PVD) / peripheral artery disease (PAD) / Raynaud's
- GU: kidney disease / stones / bladder infection / burning with urination / urinary incontinence
- MENTAL HEALTH: anxiety / depression / dependency on alcohol or medications or drugs
- RESPIRATORY: lung cancer / short of breath / pneumonia / emphysema / bronchitis / asthma / tuberculosis (TB) / other lung disease
- STROKE: mini-stroke / TIA/ full-deficit stroke (Describe residual symptoms: _____)
- ENDOCRINE: hypothyroid / hyperthyroid / hot or cold intolerance / excessive sweat / diabetes
- MUSCULOSKELETAL: pain in arms or legs at rest or during walking or exercise / wounds / swelling
- SKIN / BREASTS: skin lesions or cancer / breast lumps, cancer /nipple discharge / skin, nipple change
- NEUROLOGICAL: neuropathy / numbness / tingling / dizziness / unsteadiness / restlessness
- ALLERGIC/ IMMUNOLOGIC: allergy to _____ / sickle cell disease or trait
- OTHER HEALTH ISSUES (not listed above) _____

Please check here if you have not had any of the above symptoms or illnesses

HAS ANY BLOOD RELATIVE HAD: (Please circle and list relationship)

VARICOSE VEINS / BLOOD CLOTS / HEART ATTACK / BLEEDING TENDENCY / CANCER / HIGH FEVER AFTER SURGERY

SOCIAL HISTORY: (Please circle)

ARE YOU A: NONSMOKER? SMOKER? EX-SMOKER? HOW MANY PACKS / DAY? _____
DO YOU DRINK ALCOHOL, WINE, OR BEER? Y N HOW MUCH PER WEEK? _____

WOMEN ONLY: NUMBER OF PREGNANCY _____ LIVE BIRTHS _____ MISCARRIAGE _____
DO YOU PLAN TO HAVE MORE CHILDREN? Y N
ARE YOU STILL ABLE TO HAVE CHILDREN? Y N. IF NO, CIRCLE REASON: tubes tied , hysterectomy, menopausal, partner had vasectomy, other: _____

PATIENT SIGNATURE _____ **DATE** _____ **MIMI LEE, M.D.**