

MEDICAL HISTORY

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Patient Name:	Height:	Weight:
Family Physician:	Phone Number:	

Please list any medical conditions that you have. If none, please check none. None

Please list any surgeries or hospitalizations you have had in the past. List year. If none, please check none. None

Please list all medications you are currently taking. (Include birth control pills, vitamins, supplements, etc.)
Please include strength (how many milligrams & how many times a day you take it). If none, please check none. None

Medication	Dose	Frequency	Medication	Dose	Frequency

Please list all medications to which you are allergic and type of reaction you had. If none, please check none. None

Are you allergic to latex? Yes No

Family History

My family members have a history of the following medical problems. Check yes or no.

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Which family member and what kind?	_____	
Blood vessel disease (circulation problems)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please circle the correct answer below:

Have you ever been tested for the Aids Virus (HIV)?	Yes	No	If yes, what were the results:
			Positive or Negative
Do you smoke?	Yes	No	If yes, how much per day?
Caffeine in a day?			If yes, how much per day?
Do you drink alcohol?	Yes	No	If yes, what and how often?
Do you use social drugs?	Yes	No	
Are you pregnant or have any reason to think you might be?	Yes	No	
Please give approximate date of last menstrual period, if applicable:			

Review of Systems

Do you have or have had any of the following? Check Yes or No.

<p>Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Valve <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Year _____</p> <p>Bleeding Tendencies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Transfusions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bone Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Defibrillator <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Year _____</p> <p>Depression <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ever Treated for Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Year _____</p> <p>Heart Attack in Past <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Year _____</p> <p>Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heartburn, Frequent <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Kidney Stones <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea or Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Past Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Year _____</p> <p>Prolonged Bleeding from Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rectal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Severe Nosebleeds <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Take Coumadin, Blood-Thinners, Plavix, Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No (circle one) Dose _____</p> <p>Think I'm at High Risk for AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcer Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcers in Past <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urination, Frequent <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urination, Painful <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urination, Slow <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Veneral Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wear Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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I hereby state that the above information is true and correct to the best of my knowledge.

Signature

Date

Print Name