

Elliot M. Livstone, M.D., F.A.C.P., F.A.C.G., P.A. - History form

NAME: _____

What is your present complaint? _____

PLEASE LIST YOUR PRESENT MEDICATIONS. (Use other side if necessary.)

PLEASE LIST ALL VITAMIN AND HERBAL PREPARATIONS AS WELL.

| Drug Name | Dose | How often? |
|-----------|------|------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Are you allergic to any medicines or have you had any bad reactions to medicines?

_____ If yes, please list them(use other side if necessary).

Have you ever had or has a doctor told you that you had any of the following? Place an "X" to the right of the word or phrase for "yes" answers; if "no", leave the line blank.

- | | | |
|---------------------------|--------------------------|------------------------|
| Heart disease_____ | High blood pressure_____ | Heart failure_____ |
| A Heart Attack_____ | Heart Murmur_____ | Arrhythmia_____ |
| Diabetes_____ | Pneumonia_____ | Emphysema_____ |
| Kidney disease_____ | Bleeding Problems_____ | Stroke or TIA_____ |
| Cancer_____ | Anemia_____ | Ulcer_____ |
| Colitis_____ | Diverticulitis_____ | Hiatus Hernia_____ |
| Spastic bowel_____ | Food Allergy_____ | Other Type hernia_____ |
| Gall Bladder Trouble_____ | Pancreas Trouble_____ | Hepatitis_____ |
| Jaundice_____ | Pacemaker_____ | Artificial Parts_____ |
| Glaucoma_____ | Thyroid Disorder_____ | Anorexia_____ |
| Bulimia_____ | Psychiatric problem_____ | |

PLEASE ANSWER YES OR NO:

Have you ever vomited blood? _____

Have you ever passed bright blood in your bowel movements? _____

Does milk give you diarrhea, gas, cramps, or bloating? _____

Do you see mucus _____ or "oil droplets" in your bowel movements? _____

Has a doctor ever told you that you need to take antibiotics for dental work? _____

Have you gained weight this past year? _____ How much? _____

Have you lost weight this past year? _____ How much? _____

History Form

Have you ever had an operation? _____ If yes, please list year, name of hospital, and operation? Use other side if necessary. Use other side if necessary.

| Year | Hospital | Operation |
|------|----------|-----------|
| | | |
| | | |

Have you ever been hospitalized for any non-surgical reason? _____ If yes, please indicate year, name of hospital, and reason (illness). Use other side if necessary.

| Year | Hospital | Reason (type of illness) |
|------|----------|--------------------------|
| | | |
| | | |

Have you ever had a transfusion _____? If yes, when _____?

REVIEW OF SYSTEMS:

Please place an "X" to the left of the word or phrase if you have any of the following:

- Appetite: _____ Loss of appetite _____ Excessive appetite?
- Sleep _____ Loss of sleep _____ Inability to fall asleep or stay asleep?
- Senses: _____ Vision _____ Cataracts _____ Hearing _____ Hearing Aids?
_____ Impaired sense of smell _____ Impaired sense of taste?
- Mouth: _____ Mouth ulcers _____ Sore mouth _____ Dentures _____ Lip sores?
_____ Poorly fitting dentures _____ Bad breath _____ Bleeding gums?
- Respiratory: _____ Sore throat _____ Cough _____ Sputum production?
- Cardio: _____ Exertional chest pain _____ Exertional shortness of breath?
_____ Shortness of breath in bed _____ Ankle swelling _____ Palpitations?
- GI: _____ Painful swallowing _____ Difficulty swallowing _____ Frequent belching?
_____ Heartburn (burning sensation under the breastbone)?
_____ Food sticking in your food pipe _____ Nausea _____ Vomiting?
_____ Vomiting blood or material resembling coffee grounds?
_____ Passing excess gas from your rectum?
_____ Jaundice (The whites of your eyes turning yellow)?
_____ Distension of your abdomen _____ A lump or mass in your abdomen?
_____ Diarrhea _____ Constipation _____ Abdominal pain _____ Rectal pain?
_____ Black or tarry bowel movements _____ White or gray bowel movements?
_____ Blood in your bowel movements _____ Recent change in bowel pattern?
- GU: _____ Difficulty urinating _____ Burning on urination _____ Bloody urine?
_____ Dark urine (like iced tea or Coca Cola)? _____ Cloudy urine?
- GYN: _____ Vaginal bleeding _____ Vaginal discharge _____ Vaginal itching?
- NEURO: _____ Fainting _____ Balance problems _____ Seizures _____ Tremors?

History Form

SOCIAL HISTORY:

What is your present occupation? _____

What was your previous occupation? _____

Have you ever been exposed to any occupational hazards? _____

If yes, what kind? _____

Have you been exposed regularly to any industrial chemicals? _____

If yes, what kind? _____

Do you smoke now? _____ If yes, how much? _____

How long have you smoked? _____

Have you ever smoked before? _____ If yes, for how long? _____

How much did you smoke? _____ When did you stop? _____

Have you ever taken drugs by injection for recreation? _____

What type? _____

How long ago? _____ Did you share needles? _____

How often do you take Aspirin products? _____

How often do you take non-steroid anti-inflammatory drugs such as Advil, Aleve
Anaprox, Clinoril, Feldene, Naprosyn, Motrin, Relafen, etc.? _____

DIET HISTORY:

How much regular coffee, regular tea, or regular iced tea do you drink? _____

How much regular or diet cola beverages do you drink each day? _____

How many glasses or cups of other fluids do you drink each day? _____

Do you drink alcohol-containing beverages? _____ If yes, how much? _____

If no, have you consumed alcohol in the past? _____

If yes, how much? _____ For how long? _____

How many times per week do you eat raw fruit? _____

How many times per week do you eat raw vegetables or salads? _____

How many times per week do you eat cooked vegetables? _____

How much bran do you eat? _____

Do you live alone? _____

If no, who lives with you? _____

Do you cook for yourself? _____

If no, who cooks for you? _____

History Form

FAMILY HISTORY:

For each family member requested, please indicate whether the person is alive or dead. If alive, please state age and describe general health (or list major health problems). If deceased, please state age of death and cause of death.

Alive / Dead Age

General Health / Cause of Death

Father _____

Mother _____

Brothers _____

Sisters _____

Children _____

IS THERE ANYTHING ELSE THAT THE DOCTOR SHOULD KNOW THAT HAS NOT BEEN ASKED SO FAR? IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO TELL THE DOCTOR?

If yes, please explain here. _____

BEFORE BRINGING THIS FORM TO THE OFFICE AND GIVING IT TO THE RECEPTIONIST, PLEASE REVIEW YOUR ANSWERS TO MAKE SURE THEY ARE ACCURATE AND COMPLETE. THANK YOU.