Susan E. Downey, MD

PATIENT'S PERSONAL HISTORY

Confidential record: Information contained herein will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in his/her decisions regarding your care.

First Name ________________________________ **Middle Name** __________ **Last Name** ___________________________________

Age ___________ **Ht** ___________ **Wt** ___________ **Sex** M F **Marital Status** S M W D

Date of Last Physical Exam ____________________ **Date of last chest x-ray?** ________________

Primary Care Physician **Address** **City/State/Zip** **Phone**

Referring Physician **Address** **City/State/Zip** **Phone**

Oncologist Physician (if applicable) **Address** **City/State/Zip** **Phone**

Do you have or have you had: (Please CIRCLE. If yes, give date of occurrence.)

STROKE	NO YES _______	ARTHRITIS	NO YES _______	KIDNEY DISEASE	NO YES _______
CANCER	NO YES _______	MIGRAINE	NO YES _______	TONSILITIS	NO YES _______
TUBERCULOSIS	NO YES _______	HAY FEVER	NO YES _______	RHEUMATIC HEART	NO YES _______
LEUKEMIA	NO YES _______	COLITIS	NO YES _______	BLEEDING TENDENCY	NO YES _______
BRONCHITIS	NO YES _______	GOITER	NO YES _______	HIGH BLOOD PRESSURE	NO YES _______
EPILEPSY	NO YES _______	BLADDER INFECTION	NO YES _______	CONGENITAL HEART	NO YES _______
PNEUMONIA	NO YES _______	ASTHMA	NO YES _______	NERVOUS BREAKDOWN	NO YES _______
DIABETES	NO YES _______	HEART ATTACK	NO YES _______	HIV/AIDS	NO YES _______
HEPATITIS	NO YES _______	STOMACH ULCERS	NO YES _______		

List any other serious illnesses which you have had: ____

____

Are you allergic to any medications: **yes**_____ **no** _____

Name any drugs to which you are allergic and list your reaction to each drug:

____

____

Please list any herbal supplements you are currently taking:

______________________________ ______________________________ ______________________________

Do you smoke regularly? NO YES **How much?** ______________________________ **How many years?** __________________

Do you regularly drink alcohol or beer? NO YES **How much?** ____

Do you usually drink over 6 cups of coffee per day? NO YES ____________________

PATIENT'S PERSONAL HISTORY (continued)

Are you presently taking any of the following medications? (Please CIRCLE)

Aspirin, Bufferin, Anacin	NO YES	Blood Pressure Pills	NO YES	Cortisone	NO YES
Cough Medicine	NO YES	Digitalis	NO YES	Hormones	NO YES
Insulin or Diabetic Pills	NO YES	Laxatives	NO YES	Sleeping Pills	NO YES
Iron or Poor Blood Medication	NO YES	Thyroid Medication	NO YES	Headache Pills	NO YES
Medicine for Arthritis	NO YES	Tranquilizers	NO YES	Weight Reducing Pills	NO YES
Blood Thinning Pills	NO YES	Dilantin	NO YES	Shots	NO YES
Water Pills	NO YES	Antibiotics	NO YES	Other Drugs Not Listed	NO YES
Barbituates	NO YES	Birth Control Pills	NO YES	________________	NO YES
Phenobarbital	NO YES			________________	NO YES

Please list medications you are currently taking:

Medication	*Frequency*	*Last Taken on*

Please list all surgeries which you have had:

SURGERY	DATE	HOSPITAL	PHYSICIAN

Do you frequently have bleeding gums? NO YES **Have you ever bled excessively from a tooth extraction?** NO YES

Do you have nose bleeds? NO YES **How often?** ____________________

Do you take aspirin regularly? NO YES **How often?** ____________ **(IF YES, STOP TAKING THEM UNTIL AFTER YOUR SURGERY)**

WOMEN ONLY

Have you ever had a discharge from the nipple of your breast? ____________ When? ____________

How many children born alive? ____________ How many miscarriages? ____________

How many abortions? ____________ How many cesarean operations? ____________

Date of last menstrual period: ____________

Date of last mammogram: ____________ Result: ____________

Where was it done? ____________ Phone Number: ____________

Address: ____________

NOTE: We recommend regular breast and pelvic exams by your Primary Care Physician

MEN ONLY

NO YES Have you had treatment for your genitals (private parts)?

NO YES Have you ever had discharge from your penis?

Patient Signature____________________ **Date**____________