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

Primary Occupation:_____ **Education: (highest level achieved)** _____

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:

PATIENT'S PERSONAL HISTORY (continued)

Smoking History (mark one) ☐ Never smoked/used tobacco products ☐ Currently smoke/use tobacco products

☐ Formerly smoked/used tobacco products: Date stopped: ____/____/____

If a current or former tobacco user, number of cigars/cigarettes/pipes _____ Mark one: ☐ per day ☐ per week ☐ per month

How many years? _____

Alcohol History (mark one) ☐ Never consumed alcohol ☐ Currently consumes alcohol

☐ Formerly consumed alcohol: Date stopped: ____/____/____

If a current or former alcohol consumer, indicate quantity per timeframe and duration:

Quantity (mark one) 1 unit equals:

☐ < 1 unit -12 oz beer (one bottle or can)

☐ 1-4 Units - 1 oz of alcohol (whiskey, gin, rum, vodka, etc.)

☐ >4 units - 6 oz of wine (a standard glass)

Mark one: ☐ per day ☐ per month ☐ per year

How many years?_____

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

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)**

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: _____

PATIENT'S PERSONAL HISTORY (continued)

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

Patient Signature_____**Date**_____