norma j. kusnetz, m.d.

PATIENT MEDICAL HISTORY

Today's Date: ____________

Patient's Legal Name: ______________________________ Date of Birth: ____________
Last First M

If Minor, Parents' Names: ______________________________

Reason For Visit: ______________________________

How did you hear about us? Internet/Website Billboard Referral by: ______________

Do you have any allergies or reactions to medications? Yes No (list below)

1. ______________ 3. ______________
2. ______________ 4. ______________

List chronic medical conditions, e.g., high blood pressure, diabetes, cholesterol, low thyroid, etc...

1. ______________ 5. ______________
2. ______________ 6. ______________
3. ______________ 7. ______________
4. ______________ 8. ______________

Please list all surgery you have had and include date (month/year)

1. ______________ 5. ______________
2. ______________ 6. ______________
3. ______________ 7. ______________
4. ______________ 8. ______________

Please list all current medications including prescription and non prescription drugs, e.g., aspirin:

1. ______________ 6. ______________
2. ______________ 7. ______________
3. ______________ 8. ______________
4. ______________ 9. ______________
5. ______________ 10. ______________

Scans/Tests:
Have you had any of the following? How recently?

Colonoscopy	Yes	No	Date: ______
Endoscopy (EGD)	Yes	No	Date: ______
Dexa Scan	Yes	No	Date: ______
PSA	Yes	No	Date: ______
Stress Test	Yes	No	Date: ______
Mammogram	Yes	No	Date: ______
Pap smear	Yes	No	Date: ______

Immunizations/Vaccines:
Have you had any of the following? How recently?

Flu	Yes	No	Date: ______
Shingles	Yes	No	Date: ______
Pneumonia	Yes	No	Date: ______
Meningitis	Yes	No	Date: ______
Tetanus Booster	Yes	No	Date: ______
Gardisil Series	Yes	No	Date: ______

Are you currently having or have you had *(check all that apply)*:

Fever	Night Sweats	Chills	Swollen Lymph Nodes
Weight Loss	If so, How Much? ____________ Lbs.		
Nausea	Vomiting	Abdominal Pain	Food Intolerance
Vomiting Blood	Rectal Bleeding	Blood In Urine	
Asthma	COPD	Sleep Apnea	Do You Use Oxygen?
Chest Pain	Shortness of Breath	Swollen Legs	Yes No
Kidney Failure	Kidney Stones	Dialysis	Heart Stents
Anemia	Clotting Problems	Excessive Bleeding	Low Platelets
Lupis	Fibromyalgia	Migraine Headaches	Endrometriosis
Diabetes	Low Blood Sugar	Weakness	Chronic Fatigue
Hepatitis: A B C		HIV/AIDS	MRSA

Family History: Do you have a family member who is or has been diagnosed/treated for:

	FATHER	MOTHER	BROTHER	SISTER	OTHER RELATIVE (Please List & Paternal/Maternal)
Cancer ____________ *(which type)*					____________
Heart disease					____________
High Blood pressure					____________
High cholesterol					____________
Diabetes					____________
Alzheimers/Parkinsons					____________
Rheumatoid Arthrits					____________
Osteoporosis					____________
AIDS/HIV					____________
Hepatitis C					____________
Tuberculosis					____________

Social History:

Current occupation ______________________________ Retired Yes No

Education: High School College Graduate School

Marital status: Single Married Divorced Widowed

Do you drink alcohol? Yes No If, Yes how many drinks per day? ____________

Do you smoke cigarettes? Yes No If, Yes how many packs per day? ____________

Do use smoke marijuana? Yes No If Yes, how often? Daily Weekly Monthly

Have you ever: Used intravenous drugs? Yes No

Had a Blood Transfusion? Yes No

Signature of patient or guardian: ______________________________ Date: ____________