Patient History
Dr. Donald Elmajian

Patient Name: ____ M ___ F ___ Today's Date _____________
DOB: ______________ Age: ________ Primary Care MD: ________________________________

Chief Complaint: (Why are you seeing the doctor today?) :
____

Past Medical History. Please mark all that apply:

□ *No Past Medical History*
□ Alzheimer's disease
□ Arthritis
□ Blood Clot(s); when? ______________
□ Cancer; type ______________________
□ COPD
□ Congestive heart failure (CHF)
□ Coronary artery disease
□ Depression
□ Dementia
□ Diabetes Type 1
□ Diabetes Type 2
□ GERD (gastric reflux)
□ Gout
□ Heart attack, year: ____________
□ Hepatitis
□ High blood pressure
□ High cholesterol
□ Migraines
□ Peptic ulcer disease
□ Peripheral Vascular disease
□ Renal (kidney) disease
□ Rheumatoid arthritis
□ Seizure disorder
□ Stoke, year: ___________
□ Thyroid disease
□ Other: ____
□ Other: ____

Past Surgical History. Please mark all that apply:

□ *No Past Surgical History*
□ Appendectomy (appendix removal)
□ Back Surgery
□ CABG (heart bypass)
□ Colon surgery
□ Coronary (heart) stent(s)
□ Chemotherapy/Radiation therapy
□ Gastric bypass
□ Gallbladder removal
□ Bladder surgery, type: _______________
□ Hernia repair, type _____________________
□ Partial Hysterectomy
□ Total Hysterectomy
□ Hemorrhoidectomy
□ Hip replacement (left/right/both)
□ Knee replacement (left/right/both)
□ Kidney stone removal
□ Kidney surgery, type: ____________________
□ Pacemaker
□ Prostate surgery; type: ____________________

□ Other: ____

Family History: □ Adopted/Family history not known

Please list immediate family members who have died and the cause of death: (ex: father – lung cancer)
____

Please check all family history that applies:

	Mother	Father	Sister	Brother	Other		Mother	Father	Sister	Brother	Other
Blood disease						Kidney Cancer					
Bladder cancer						Kidney Stones					
Diabetes						Prostate Cancer					
Heart disease						Stroke					
Hypertension						Other: _____________					
Kidney disease						Other: _____________					

Patient Name: ___________________________________ Date of Birth: ____________________

Social History:

What is your current occupation? (*example: teacher*) __________________________________

or if retired, what was your previous occupation? ______________________________

Tobacco Use:

- □ I have never used tobacco products
- □ I am a former user of: □ Cigarettes □ Chewing tobacco □ Cigars □ Pipes
  - Approximately what age did you quit using tobacco? _________
- □ I currently use tobacco products
  - □ Cigarettes: ____ pack(s) per day for _____ years
  - □ Chewing tobacco: ______ cans/pouches per day for _____ years
  - □ Cigar/Pipe: _______ # per day for ______ years

Alcohol Use:

- □ I never drink alcohol.
- □ I drink alcohol socially.
- □ I drink alcohol weekly.
- □ I drink alcohol daily. What type? _______________ How much?_______________

Caffeine Use:

- □ I do not use caffeine
- □ I rarely use caffeine
- □ I use caffeine daily. Type: ___________________

Do you feel safe in your environment? ____ Yes _____ No

Review of Systems:

Please select if you have a *recent* history of any of the following:

□ Double vision
□ Blurred vision
□ Eye pain
□ Dyspnea (difficulty breathing)
□ Chest pain
□ Heart palpitations
□ Abdominal pain
□ Nausea
□ Vomiting
□ Blood in stool
□ Urinary incontinence
□ Fatigue
□ Difficulty walking
□ Headaches
□ Seizures
□ Anxiety
□ Depression
□ Skin rash
□ Back pain
□ Easy bleeding
□ Asthma

□ **None of the above**

Have you fallen in the last 6 months? □ YES □ NO

Female patients only:

Obstetric History:

Total # of pregnancies __________ Total # of deliveries __________

Vaginal ______C-Section _______ Weight of largest baby ____lbs _____ oz.

Patient Name: ______________________________________ DOB: ________________________

MEDICATION LIST

Please list all medications you are currently taking. Include prescription (pills, inhalers, creams, shots, etc.), over-the-counter medicine (aspirin, antacids, etc.) and herbals (ginseng, gingko, etc.). Remember to include medications that are only taken as needed.

□ I do not take any prescription or over the counter medications

Medication Name	Dose	Directions	Reason for Medication
Example: Lisinopril	*10 mg*	*One pill every morning*	*High blood pressure*
Example: Ambien	*5 mg*	*One pill at bedtime as needed*	*Sleep aid*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

What is your preferred local pharmacy? ________________________________ Street name: ________________________

What is your preferred mail-order pharmacy (if applicable) ____

Allergies:

Please list medication and food allergies and the reaction they cause. (example: Penicillin - skin rash)

Name of Medication	Reaction
1.	
2.	
3.	

□ I have no known allergies to any medications