



LISA L. JEWELL, M.D. - MICHAEL K. NEWMAN, M.D. - CHARLES W. SPENLER, M.D.

Name _____ Date of birth _____

Referred by _____

Age _____ Height _____ Weight _____ Why are you seeing the doctor today? _____

List all hospitalizations and operations (including cosmetic surgery)

Year	Hospital/Operation Type	Year	Hospital/Operation Type
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all current daily medications (include vitamins, herbs, and over-the-counter medicines)

Does anyone in your family have (list which family member):

- Diabetes _____
- Cancer _____
- Stroke _____
- Hypertension _____
- Heart Disease _____
- Other _____

List all allergies (including latex)

Do you presently have or have you frequently had:

- | | | | |
|--|--|---|--|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> <input type="checkbox"/> Anemia or Bleeding Tendency | <input type="checkbox"/> <input type="checkbox"/> Frequent Nasal Bleeding |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> <input type="checkbox"/> Seizures/Fainting Spells | <input type="checkbox"/> <input type="checkbox"/> Frequent Ear Problems |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> <input type="checkbox"/> Back or Neck Injuries | <input type="checkbox"/> <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> <input type="checkbox"/> Regularly take Aspirin or Steroids | <input type="checkbox"/> <input type="checkbox"/> Visual impairment/cataracts/dry eyes |
| <input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis/Blood Clots | <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> <input type="checkbox"/> Take Weight-Reducing Medication? | <input type="checkbox"/> <input type="checkbox"/> Cold Sores/Herpes |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <input type="checkbox"/> Transfusions | <input type="checkbox"/> <input type="checkbox"/> Keloid/Hypertrophic Scars | <input type="checkbox"/> <input type="checkbox"/> Have you used Retin-A? |
| <input type="checkbox"/> <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Breast Lumps or Discharge | <input type="checkbox"/> <input type="checkbox"/> Have you ever taken Accutane? |
| <input type="checkbox"/> <input type="checkbox"/> Asthma/Emphysema/Wheezing | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> <input type="checkbox"/> Breast Implants | <input type="checkbox"/> <input type="checkbox"/> Hernia of _____ |
| <input type="checkbox"/> <input type="checkbox"/> Pneumonia or Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss or Gain (amount) _____ | |
| <input type="checkbox"/> <input type="checkbox"/> Fractures? Where? _____ | | <input type="checkbox"/> <input type="checkbox"/> Cancer (location/date) _____ | |
| <input type="checkbox"/> <input type="checkbox"/> Other Health Issues _____ | | | |

Social History (check the appropriate box response or fill in the blank)

- Smoking:** yes no in the past (list year you quit _____)
- Alcohol:** frequently occasionally rare never
- Marital Status:** single married divorced widowed **Occupation:** _____

Female patients:

Mammogram (date) _____ Location _____ Results _____

Number of Pregnancies _____ Number of Births _____ Method of Birth Control _____

Could you be pregnant now? Yes No Are you attempting pregnancy? Yes No

I certify that I have disclosed my medical history to the best of my knowledge.

Patient Signature _____ Date _____

Physician Signature _____ Date _____