

NEW ADULT PATIENT HISTORY INTAKE

Welcome to the medical practice of Richard Podolny MD LLC. A complete and thorough medical history helps us to help you!

Personal History

Name: _____ Date of Birth ___/___/___ Age ___ Date: _____
Occupation _____ Birthplace _____ Date of Last Examination _____
Referred by: _____

ALLERGIES: Please list medications, foods, and environmental agents. Please also list type of reactions to each.

_____	_____
_____	_____
_____	_____
_____	_____

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____
4. _____
5. _____

Additional problems or concerns you would like addressed:

*Note: we may not be able to address every problem during the course of one visit.

Current Medications (Use additional sheet if necessary)

Dose

Times / Day

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Herbs / Vitamins/ Supplements

Dose

Times / Day

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL AND FAMILY HISTORY.

Check those that apply to conditions for which you or your family have been diagnosed or treated. If a family member has died as a result please mark with the letter D and the date.

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
HIV/AIDS							
Alcohol or Drug abuse							
Allergies							
Alzheimer's							
Anemia							
Anorexia/bulimia							
Arthritis							
Asthma							
Back Problems							
Bipolar disorder							
Birth Defects							
Bleeding Disorder							
Breast Disease/Cancer							
Cancer (Other)							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack/							
Heart Disease/murmurs							
Heart Failure							
Hemorrhoids							
Herpes							
High Blood Pressure							
High Cholesterol							
Irritable Bowel Syndrome							
Kidney/Bladder Disease							
Gall bladder/Liver Disease							
Mental Illness							
Migraine Headaches							
Pelvic infections/STD							
Pneumonia							
Prostate Cancer							
Rheumatic Fever							
Seizures/epilepsy							
Sickle Cell Anemia							
Skin Problems							
Stroke							
Suicide							
Tuberculosis							
Thyroid problems							
Ulcers/reflux disease							
Other							

PAST HOSPITAL, SURGICAL & TRAUMA HISTORY

Patient Name: _____

List prior injury, hospitalization, surgery, motor vehicle accidents, and/or trauma:

Reason: _____

Date: _____

SOCIAL HISTORY (check those that apply):

Patient Name: _____

Marital status:

- single
 married
 divorced
 Widowed

Education level completed:

- high school
 college
 professional school
 other: _____

Memories of your childhood

- Mostly happy
 Mostly painful
 Normal
 don't recall

Do You Find Your Life

- Generally Unsatisfactory
 Too Demanding
 Boring
 Satisfactory

Living arrangement:

- alone family roommate significant other

children (list sex/ages): _____

- Major stresses in last 6 months Money Job Marriage Home Life Children

other stressors _____

Pertinent travel history:(out of USA, epidemic areas)**LIFESTYLE / SELF-CARE ISSUES**

- Do you smoke cigarettes? YES NO If yes, # _____ yrs. _____ packs /day
- Did you ever smoke? YES NO If yes, When did you quit? _____ # _____ years _____ packs/ day
- Do you drink alcohol? YES NO If yes, #yrs. _____ Type _____ & _____ drinks per week
- Did you ever drink alcohol? YES NO If yes #yrs. _____ Type _____ & _____ drinks per week
- Do you drink caffeinated beverages? YES NO If yes, which? _____
- Do you use recreational drugs? YES NO If yes, which? How much? _____
- Did you ever use recreational drugs? YES NO If yes, which? How much? _____
- Do you manage stress well? YES NO NOT SURE NEED HELP
- Do you exercise regularly? YES NO If yes, how much? If no, why? _____
- Do you enjoy your job? YES NO If no, why? _____
- Do you allow time to unwind and relax? YES NO If no, why? _____
- Do you sleep soundly? YES NO If no, why? _____
- Are you satisfied with your sex life? YES NO If no, why? _____
- Are you satisfied with your social life? YES NO If no, why? _____
- Are you satisfied with your spiritual life? YES NO If no, why? _____
- Is your diet healthy enough? YES NO NOT SURE NEED HELP

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Typical snacks _____

Review of Systems Part I

Please check box as appropriate. Leave blank if not present

Symptom	Duration			Symptom	Duration		
	Days	Wks	Mn/ Yrs		Days	Wks	Mn/ Yrs
Constitutional				Immune system			
poor appetite				too many infections			
fevers				allergies to food			
chills				allergies to environment			
food craving				swollen lymph nodes			
weight loss				unusual thirst			
weight gain				intolerance to heat or cold			
fatigue				other concerns			
Eyes				Heart/Blood			
eye pain				swollen lymph glands			
blurred vision				anemia			
poor vision – day				easy bruising			
poor vision – night				heart and circulation			
wear corrective lenses				chest pain			
nearsighted				lightheadedness/feinting			
farsighted				palpitations			
double vision				cold hands/feet			
				fainting			
Ear, nose, mouth, throat				swelling feet/legs			
ringing in ears				blood clot			
nosebleed				varicose veins			
postnasal drip				shortness of breath with exercise			
sinus problems				needs many pillows to sleep			
trouble tasting/smelling				awakes at night with trouble breathing			
poor hearing				leg pain with exercise			
earaches							
headaches				Breathing and lungs			
jaw clicks				shortness of breath			
teeth problems				wheeze or asthma			
grinding teeth				repeated cold/flu			
trouble chewing				cough dry/irritating			
facial pain				coughing up blood			
sore throat				night sweats			
mouth sores							
bad breath							
vertigo							
neck stiffness							
neck masses							

Review of Systems Part II

Please check box as appropriate. Leave blank if not present

Symptom	<i>Duration</i>			Symptom	<i>Duration</i>		
	Days	Wks	Mn/ Yrs		Days	Wks	Mn/ Yrs
Muscles, bones, joints				Sexual organs			
neck pain				sores on genitals			
back pain				lumps or swelling			
muscle pain				erection problems			
painful joints				for sexual response			
shoulder – left, right				pain with sex			
elbow – left, right				infertility			
wrist – left, right				repeated infections			
hip – left, right							
knee – left, right				Women			
ankle – left, right				pelvic pain			
joint swelling				vaginal discharge			
muscle weakness				painful periods			
muscle cramps				premenstrual syndrome			
decreased range of motion				hot flashes			
				itching or soreness			
Skin, hair, breast				pain with sex			
breast lumps or pain				genital sores			
breast leaks fluid				decreased sex drive			
rashes							
itching, hives				Nerves, movement, brain			
hair loss/gain				seizures /convulsions			
dry skin, eczema				nerve pain			
hair changes				poor balance			
				poor coordination			
Urine, kidney, bladder				tremors or shaking			
painful urination				memory difficulties			
wake up often to urinate							
kidney stones				Digestion			
loss of control				indigestion			
frequent urination				belching			
sudden urge				difficulty swallowing			
blood/pus in urine				heartburn			
decreased urine output				nausea			
erection problems				liver trouble			
decreased sex drive				vomiting			
pelvic pain				diarrhea			
				cramping bowels			
Psychiatric				gassy gut			
depression				constipation			
anxiety				abdominal pain			
previous psychiatric care				rectal pain/itching			
hallucinations				hemorrhoid/piles			
hearing voices				blood in stool			
unusual perceptions				throwing up blood			

DEVICES**Do You Use:**

___Eyeglasses ___Contact Lens ___Hearing Aid ___Dentures
 ___Brace (Neck, Back) ___Pacemaker ___IUD, Diaphragm ___Artificial Limbs
 ___Dentures ___Wheelchair ___Cane

OB / GYN HISTORY

How many times have you been pregnant ___ Live births ___ Miscarriages ___ Terminations ___
 Date of last menstrual period _____ Normal (yes/no) Days of bleeding _____
 How many days from first day of menses to first day of next menses _____
 Age of first menses _____ Date of last Pap smear _____
 History of abnormal Pap smears _____
 History of colposcopy _____ If yes, When _____
 Type of contraception use presently _____
 Types of contraception use in the past _____

HEALTH SCREENING HISTORY**Patient Name:**

List the date of your most recent test or exam.

Mammogram _____ Pap Smear _____ Self Breast Exam _____ Breast Exam by Doctor _____
 Blood test for Cholesterol _____ Blood Sugar _____ Other Blood tests _____
 Immunizations: Polio _____ Tetanus _____ Hepatitis _____ Pneumonia _____ Flu Shot _____
 Test for Blood in stool _____ Rectal Exam _____ Feeling the Prostate _____ Scope Lower Bowel _____
 Self Exam Testicle _____ Testicle Exam by Professional _____ X ray scan for osteoporosis _____
 Do you have Advanced Directives in case of terminal illness or permanent vegetative state _____

IMAGING HISTORY--PLEASE PROVIDE APPROXIMATE DATES IF POSSIBLE.

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	Pet Scan	EMG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other							

This is a confidential record . Information contained here will not be released to anyone without your authorization to do so.

Date Patient/Guardian signature who filled out the history

Date Physician Signature