Steven Peskind, M.D. & Associates, P.A.

Patient Name: _____ Date: _____

Whom may we thank for referring you to our office: _____
Please list all other physicians that are treating you at this time: _____
_____

Social History:

Tobacco Use:	Yes	No	How much: _____
Alcohol Use:	Yes	No	How much: _____
Are you pregnant:	Yes	No	

Past Medical History:

Childhood Diseases:

_____ Seizures	_____ Polio	_____ Measles	_____ Rheumatic Fever
_____ Diptheria	_____ Mumps	_____ Scarlet Fever	_____ Whooping Cough

Other: _____

Other Medical Problems:

_____ Migraines	_____ Asthma	_____ Hepatitis	_____ Prostate
_____ Depression	_____ Stroke	_____ Bronchitis	_____ Liver
_____ RSV	_____ Sinusitis	_____ Epilepsy	_____ Emphysema
_____ Ulcers	_____ Ovarian	_____ Oral Problems	_____ Glaucoma
_____ Tuberculosis	_____ Pancreatitis	_____ Arthritis	_____ Thyroid
_____ Cataracts	_____ Mastitis	_____ Diabetes	_____ Premature Birth
_____ Hay Fever	_____ Ear Infections	_____ Intestinal	_____ Breast Disease
_____ Anemia	_____ Angina	_____ Gallstones	_____ Trouble Hearing
_____ Colitis	_____ Phlebitis	_____ Nosebleeds	_____ High Blood Pressure
_____ Heart Murmur	_____ Cough	_____ Clotting	_____ Bladder Infections
_____ Cancer	_____ Heart Disease	_____ Allergies	_____ Kidney Infections

Other: _____

Past Surgery/Hospitalization History:

Have you ever had surgery or been hospitalized? Yes No
If yes, please explain what type of surgery and when or dates of hospital stay and condition:
_____

_____

Family History:

Please list any pertinent family health concerns. Please list the family member and the health condition:
_____

_____

Current Medications and Drug Allergies:

Please list all medications the patient is taking, including prescription, non-prescription and herbal supplements: _____

_____

Please list all known drug allergies: _____

Or circle: No known drug allergies

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Patient Name: _____ **Date:** _____

Constitutional:

Loss of appetite	___ Yes	___ No
Sweats	___ Yes	___ No
Fever	___ Yes	___ No
Weight loss	___ Yes	___ No
Weight gain	___ Yes	___ No
Fatigue	___ Yes	___ No

Respiratory:

Coughing up blood	___ Yes	___ No
Cough	___ Yes	___ No
Shortness of breath	___ Yes	___ No
Wheezing	___ Yes	___ No
Poor exercise tolerance	___ Yes	___ No
Sputum	___ Yes	___ No

Gastrointestinal:

Heartburn/indigestion	___ Yes	___ No
Black/bloody stool	___ Yes	___ No
Diarrhea	___ Yes	___ No
Nausea/vomiting	___ Yes	___ No
Jaundice	___ Yes	___ No
Abdominal pain	___ Yes	___ No
Reflux	___ Yes	___ No

Genitourinary:

Urine leakage	___ Yes	___ No
Frequent urination	___ Yes	___ No
Difficulty urinating	___ Yes	___ No
Burning with urination	___ Yes	___ No
Blood in urine	___ Yes	___ No

Allergy/Immunology:

Sneezing	___ Yes	___ No
Itchy eyes or nose	___ Yes	___ No
Hives	___ Yes	___ No

Musculoskeletal:

Stiff/sore joints	___ Yes	___ No
Muscle pain	___ Yes	___ No
Red swollen joints	___ Yes	___ No

Eyes:

Vision loss	___ Yes	___ No
Double vision	___ Yes	___ No
Redness	___ Yes	___ No
Excessive tearing	___ Yes	___ No
Itching	___ Yes	___ No

Ears/Nose/Throat/Mouth:

Hearing loss	___ Yes	___ No
Sore throat	___ Yes	___ No
Sinus congestion	___ Yes	___ No
Hoarseness	___ Yes	___ No
Tinnitus	___ Yes	___ No

Ears/Nose/Throat/Mouth: CONTINUED

Vertigo	___ Yes	___ No
Ear pain	___ Yes	___ No
Nasal drainage	___ Yes	___ No
Ear drainage	___ Yes	___ No
Itchy nose	___ Yes	___ No
Itchy ears	___ Yes	___ No
Itchy throat	___ Yes	___ No
Neck pain	___ Yes	___ No
Face pain	___ Yes	___ No
Neck lump	___ Yes	___ No
Face lump	___ Yes	___ No

Cardiac:

Palpitations	___ Yes	___ No
Shortness of breath	___ Yes	___ No
Chest pain	___ Yes	___ No
Ankle swelling	___ Yes	___ No
High blood pressure	___ Yes	___ No
Heart murmur	___ Yes	___ No

Neurologic:

Weakness	___ Yes	___ No
Seizures	___ Yes	___ No
Passing out	___ Yes	___ No
Numbness	___ Yes	___ No
Headaches	___ Yes	___ No
Dizziness	___ Yes	___ No
Tremors	___ Yes	___ No

Skin:

Unusual moles	___ Yes	___ No
Rash	___ Yes	___ No
Dryness	___ Yes	___ No
Itching	___ Yes	___ No

Hema/Lymph:

Unusual bleeding/bruising	___ Yes	___ No
Swollen nodes	___ Yes	___ No

Endocrine:

Weight gain	___ Yes	___ No
Weight loss	___ Yes	___ No
Heat intolerance	___ Yes	___ No
Excessive thirst	___ Yes	___ No
Constipation	___ Yes	___ No
Cold intolerance	___ Yes	___ No

Psych:

Nervousness	___ Yes	___ No
Memory loss	___ Yes	___ No
Hallucinations	___ Yes	___ No
Excess stress	___ Yes	___ No
Depressed mood	___ Yes	___ No

Please explain any items marked with a yes: _____

_____