JEFFREY ZURAVLEFF, M.D., P.C.

PATIENT HISTORY RECORD

NAME: _____ **Nickname** _____

DOB:___/___/_____ **Today's Date**:___/___/_____

REVIEW OF SYSTEMS : Height _____ Weight _____
Do you have any of the following problems? If yes, please explain.

GENERAL___YES___NO
(Weight loss, Fever, Change of Appetite, Night sweats)

EYES ___YES ___NO
(Cataract, Glaucoma, Vision or field of vision loss or change , Lazy eye, Macular degeneration)

EAR/NOSE/THROAT___YES____NO
(Hearing loss, Dizziness, Facial pain, Mouth sores, Difficulty swallowing, Sinus drainage or discharge)

SKIN___YES____NO
(Eczema, Psoriasis, Skin Cancer, Rashes, Keloid or Excessive scarring)

CARDIOVASCULAR___YES___NO
(Heart problems, Arrhythmia / irregular heart beat, High blood pressure, Blockage of arteries/veins, Chest pain, Ankle swelling)

RESPIRATORY___YES___NO
(Asthma, Shortness of breath, Wheezing, Chronic cough, Sleep apnea)

G.I.____YES___NO
(Abdominal pain, Vomiting, Heartburn, Diarrhea or Constipation)

MUSCULOSKELETAL___YES___NO
(Joint Pain, Swollen Joints, Muscle Fatigue, Spasms, Artificial Joints, Osteoporosis)

NEUROLOGIC___YES___NO
(Weakness, Numbness, Paralysis, Headache, Tremor, Seizures, Head trauma, Stroke)

HEMATOLOGIC ___YES___NO
(Easy bleeding or bruising, Anemia, Healing problems, Clotting problems, Blood disorder)

ENDOCRINE / METABOLIC___YES___NO
(Diabetes, Low Blood Sugar, High or Low Thyroid, High Cholesterol)

RENAL /URINARY___YES___NO
(Kidney Stones, Incontinence, Change in urination, Failing kidneys, Retain fluid, Enlarged prostate)

PSYCHIATRIC___YES___NO

(Depression, Anxiety, Memory problems, Phobia)

INFECTIOUS___YES___NO
(Swollen glands, HIV, Hepatitis, Shingles, Cold sores, Chronic sinus infection)

CANCER ____YES ____NO
(What Type , When, Treatment received)

PREGNANCY Are you currently pregnant or nursing?

FAMILY HISTORY
Are you aware of any medical condition(s) or disease(s) that run in your family?
If yes, please list:

Are you aware of a family member having difficulty with anesthesia? ___YES ___NO

SOCIAL HISTORY
Tobacco Use? ___YES___NO If yes, how many packs per day and for how long?

Alcohol Use? ___Never ___Infrequent ___Daily

Have you ever been addicted to alcohol or any form of substance? ___Yes ___No

Employed___ Unemployed __Retired ___ Homemaker___ Disabled___

Married ___ Single ___ Widowed ___ Divorced ___ Separated ___

PAST MEDICAL HISTORY
List Past Surgeries and Dates

_____ _____

_____ _____

_____ _____

_____ _____

Name of your medical doctor : _____

Date of last Physical exam : _____

_____

PLEASE STOP HERE

Staff Signature:_____ Date:_____

NAME:_____ DOB___/___/_____ Today's Date___/___/____

CURRENT MEDICATION LIST INCLUDING EYE DROPS AND OINTMENTS *

MEDICATION **DOSAGE**

1._____

2._____

3._____

4._____

5._____

6._____

7._____

*** If you have a written list of your medications please give to the staff for copying.**

Any known drug allergy? ___YES___NO If yes, please list what drug(s).

Are you allergic to Latex? ___YES ___NO

Who referred you to our practice?_____

What problem or type of problem are you experiencing? _____

_____

_____

_____

_____

_____

PLEASE STOP HERE

Staff signature_____ Date_____