Dr. DAVID YABLONSKY

DATE: _____ HOW DID YOU HEAR ABOUT US? _____

Patient's Name(last):_____(first)_____(middle)_____

DATE OF BIRTH (month)_____ (day)_____ (year)_____ AGE_____ M or F (circle)

RELATIONSHIP STATUS: married/single/widowed/divorced/involved (circle all that apply)

REASON FOR VISIT:

MEDICATIONS:

PAST MEDICAL HISTORY (check all that apply):

AIDS/HIV	Diabetes	Hepatitis	Pacemaker
Alcoholism	Diarrhea	Hernia	Parkinson's disease
Allergy(environmental)	Dizziness	High Blood Pressure	Pertussis
Anal Disorders	Diphtheria	Herniated Disc	Pneumonia
Anemia	Endocrine Disease	Herpes	Polio
Arthritis	Eating Disorders	High Cholesterol	Prostate Problems
Asthma	Epilepsy	Kidney Disease	Psychiatric
Blood Clots	Emphysema	Liver Disease	Rheumatism
Bone Disease	Fainting/Falls	Lung Disease	Rheumatic Fever
Brain Disorders	Ear, Nose, Throat	Measles	Sexual Dysfunction
Bronchitis	Fibromyalgia	Meningitis	Stroke/TIA
Cancer	Fractures	Miscarriage	Skin Disorders
Cataracts	Gonorrhea	Mononucleosis	Syphilis
Chemical Dependency	Gait Disorders	Multiple Myeloma	Swallowing Difficulty
Chicken Pox/Varicella	Gastrointestinal	Multiple Sclerosis	Thyroid Disease
Chlamydia	Glaucoma	Mumps	Tremors
Colitis	Goiter	Murmur(heart)	Tuberculosis
Connective Tissue Disease	Headache/Migraine	Muscle Disorders	Tumors/Growths
Constipation	Heart Disease	Nerve Disease	Ulcers
COPD	Heartburn	Orthopedic Disease	Urinary Tract Problems
Depression	Hemorrhoids	Osteoporosis	Vaginal Disorders

Other_____

SURGERIES(and approximate year)**:**

DAILY HABITS AND ROUTINES:

ALCOHOL (what kind, and how much per week):

TOBACCO (per day):

CAFFEINE (what kind, how much per day):

RECREATIONAL DRUGS (what and how often):

EXERCISE (specific activities and frequencies):

AVERAGE HOURS OF SLEEP PER DAY:

JOB DESCRIPTION:

RECENT FOREIGN TRAVEL:

UNUSUAL HOBBIES:

PERTINENT FAMILY HISTORY(any hereditary diseases and cause of death/age)**:**

MOTHER FATHER BROTHER(S) SISTER(S)

CHILDREN

PHARMACY (name and location/city):

MEDICATION ALLERGIES:

IMMUNIZATION HISTORY -Please indicate the date of vaccinations (if you can):

DPT (diphtheria/pertussis/tetanus)

TD (tetanus booster)

Polio

MMR (measles/mumps/rubella)

HPV (gardasil)

Pneumonia

Meningitis

Hepatitis B

Influenza

Varicella (chicken pox)

Zostavax (shingles)

PREVENTION(please answer what is applicable):

ESTIMATED DATE OF LAST:

PAP OR PELVIC EXAM _____ NORMAL? _____

MAMMOGRAM _____ NORMAL _____

BONE DENSITY SCAN _____ NORMAL? _____

LAST MENSTRUAL CYCLE _____ NORMAL? _____

COLONOSCOPY OR SIGMOIDOSCOPY _____ NORMAL? _____

DIGITAL PROSTATE EXAM _____ NORMAL? _____

PSA (PROSTATE BLOOD TEST) _____ NORMAL? _____

RECENT BLOOD TESTS (what and when) _____

RECENT STRESS TEST/ OTHER CARDIAC TESTING:
(Describe test and results):_____

Other recent testing: _____

REVEIEW OF SYSTEMS: (Circle any symptoms *you have had recently* or *frequently in the past*):

CONSITITUTIONAL:	Fever Weight loss Unusual fatigue Night sweats Poor appetite
HEAD/EYES:	Headaches Blurry vision Eye pain Eye discharge Double vision Loss of vision
EAR/NOSE/THROAT:	Ear discharge Hearing loss Ringing in ears Loss of taste Loss of smell Nasal congestion Runny nose Frequent nose bleeds Sore throat
CARDIOVASCULAR:	Chest pain/pressure Shortness of breath Palpitations Inability to lie flat Passing out Varicose veins Leg cramps *with exercise* Ankle/leg swelling
PULMONARY:	Cough Bloody cough Increased sputum volume Green sputum Blue extremities
GASTROINTESTINAL:	Difficulty/Pain with swallowing Heartburn Bowel changes Constipation Diarrhea Black or bloody stools Abdominal pain or bloating Excessive gas Frequent nausea Fecal incontinence
WOMEN'S HEALTH:	Breast lumps Nipple discharge Asymmetry of breasts Vaginal discharge Vaginal bleeding/spotting(other than normal menstruation) Difficult periods Vaginal sores/lesions Pain with intercourse Decreased libido Hot flashes
MEN'S HEALTH:	Difficulty getting and/or maintaining erections Penile sores/lesions Decreased libido Penile discharge Testicular mass Testicular pain Difficulty starting and/or maintaining urine stream
URINARY TRACT:	Frequent and/or excessive urination Painful urination Urinary incontinence Blood in urine Cloudy or dark urine Flank pain
MUSCULOSKELETAL:	Painful joints Swollen joints Difficulty with joint range of motion Muscle pain Fluid on joints
SKIN:	Sores Rash Lumps/Bumps Skin tags Suspicious moles Lesions Pallor
NEUROLOGY:	Numbness Muscle weakness Tingling Difficulty walking Poor memory Poor coordination Confusion Seizures Tremors Paralysis
ENDOCRINE:	Excessive thirst Excessive hunger Cold intolerance Heat intolerance Swollen glands
PSYCHIATRIC:	Anxiety Depression Suicidal thoughts Homicidal thoughts Apathy
OTHER:	

DO YOU HAVE A LIVING WILL? _____ (Yes or No)

PATIENT SIGNATURE _____ **DATE**_____

~END OF PATIENT'S PAPERWORK ~