

Stephen J. Pincus, M.D., F.A.C.S., Inc.

PATIENT INFORMATION

Date_____

Home phone_____

Cell Phone_____

E-mail_____

SS#_____

Name_____

Last

First

Middle

Address_____

City_____State_____Zip_____

Birthdate_____Sex_ female____male_____

Married____Single____Div.____Minor_____

Patient Employer_____

Employer
Address_____Phone_____

Occupation_____

Whom may we thank for referring you? _____

In case of emergency_____phone_____

Signature of patient, parent or guardian date

Please print patient, parent or guardian relationship

Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- Chills, Depression, Dizziness, Fainting, Fever, Forgetfulness, Headache, Loss of sleep, Loss of weight, Nervousness, Numbness, Sweats

GASTROINTESTINAL

- Appetite poor, Bloating, Bowel changes, Constipation, Diarrhea, Excessive hunger, Excessive thirst, Gas, Hemorrhoids, Indigestion, Nausea, Rectal bleeding, Stomach pain, Vomiting, Vomiting blood

EYE, EAR, NOSE, THROAT

- Bleeding gums, Blurred vision, Crossed eyes, Difficulty swallowing, Double vision, Earache, Ear discharge, Hay fever, Hoarseness, Loss of hearing, Nosebleeds, Persistent cough, Ringing in ears, Sinus problems, Vision - Flashes, Vision - Halos

MEN only

- Breast lump, Erection difficulties, Lump in testicles, Penis discharge, Sore on penis, Other

WOMEN only

- Abnormal Pap Smear, Bleeding between periods, Breast lump, Extreme menstrual pain, Hot flashes, Nipple discharge, Painful intercourse, Vaginal discharge, Other

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in: Arms, Back, Feet, Hands, Hips, Legs, Neck, Shoulders

CARDIOVASCULAR

- Chest pain, High blood pressure, Irregular heart beat, Low blood pressure, Poor circulation, Rapid heart beat, Swelling of ankles, Varicose veins

SKIN

- Bruise easily, Hives, Itching, Change in moles, Rash, Scars, Sore that won't heal

GENITO-URINARY

- Blood in urine, Frequent urination, Lack of bladder control, Painful urination

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- AIDS, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding Disorders, Breast Lump, Bronchitis, Bulimia, Cancer, Cataracts

- Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart Disease, Hepatitis, Hernia, Herpes

- High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Measles, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, Pacemaker, Pneumonia, Polio

- Prostate Problem, Psychiatric Care, Rheumatic Fever, Scarlet Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsillitis, Tuberculosis, Typhoid Fever, Ulcers, Vaginal Infections, Venereal Disease

Medications

List medications you are currently taking.

Allergies

Pharmacy Name _____ Phone _____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Occupational

Check (✓) if your work exposes you to:

	Stress	Hazardous Substance
	Heavy Lifting	Other

Occupation _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date