

ROBERT LANG, M.D., P.C.

DATE: _____

DEAR PATIENT:

THIS FORM WILL ASSIST US IN PROVIDING YOU WITH THE BEST MEDICAL CARE POSSIBLE. PLEASE TAKE THE TIME TO ANSWER EACH QUESTION ACCURATLEY AND COMPLETELY BEFORE YOU ARE SEEN. IF YOU HAVE A PROBLEM, LEAVE THE QUESTION BLANK AND GO ON TO THE REST OF THE FORM.

PLEASE NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO. PLEASE REMEMBER THAT THIS INFORMATION WILL BE RELEASED TO ANY INSURANCE COMPANY IF YOU SIGN A RELEASE. IF THERE IS SOMETHING THAT YOU DO NOT WANT TO WRITE DOWN, BUT WANT TO DISCUSS, PLEASE DO SO AT YOUR VISIT.

NAME: _____ AGE _____ DATE OF BIRTH ____/____/____

_____ SINGLE _____ MARRIED _____ DIVORCED _____ WIDOW _____ OTHER

WERE YOU REFERRED? _____ YES _____ NO IF YES BY WHOM? _____

IF NO, HOW DID YOU HEAR ABOUT OUR OFFICE? _____

DATE OF LAST PHYSICAL EXAM? ____/____/____

WHY DID YOU COME TO SEE US? _____

PLEASE LIST ALL SYMPTOMS:

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

PLEASE LIST ALL CURRENT MEDICATIONS, DOSE AND FREQUENCY:

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

*****PLEASE DO NOT WRITE BELOW THIS LINE*****

PLEASE LIST ALL OPERATIONS, HOSPITALIZATIONS, SERIOUS ILLNESS, OR ACCIDENTS:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

HAVE YOU EVER SMOKED? YES NO HOW MANY PACKS? _____ HOW MANY YEARS? _____

DO YOU SMOKE NOW? YES NO HOW MANY PACKS PER DAY? _____

DO YOU DRINK ALCOHOL? YES NO IF YES, HOW MUCH ALCOHOL DO YOU DRINK? BEERS DAY
_____ WEEK LIQUOR?(1OZ) _____ DAY _____ WEEK GLASSES OF WINE? _____ DAY _____ WEEK

HAVE YOU EVER USED ILLEGAL DRUGS? YES NO IF YES, WHEN AND HOW MUCH? _____

ARE YOU ALLERGIC TO ANY MEDICATION?

- 1. _____
- 2. _____
- 2. _____

DO YOU HAVE ALLERGIES?

- 1. _____
- 2. _____
- 3. _____

WITH WHOM DO YOU LIVE? _____

DO YOU WORK OUTSIDE YOUR HOME? YES NO

OCCUPATION(S): _____

DO YOU LIKE YOUR WORK? YES NO

HAVE YOU EVER BEEN EXPOSED TO ANY TOXINS OR CHEMICALS IN A JOB OR HOBBY? _____

FAMILY	AGE	HEALTH	IF DECEASED (AGE OF DEATH AND CAUSE)
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
BROTHER/SISTER	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
HUSBAND/WIFE	_____	_____	_____
SON/DAUGHTER	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

HAS ANY BLOOD RELATIVE EVER HAD:

- | | | | |
|---------------------|--|------------------|--|
| CANCER | <input type="checkbox"/> YES <input type="checkbox"/> NO | HIGH CHOLESTEROL | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HIGH BLOOD PRESSURE | <input type="checkbox"/> YES <input type="checkbox"/> NO | DIABETES | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| STROKE | <input type="checkbox"/> YES <input type="checkbox"/> NO | HEART TROUBLE | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| OSTEOPOROSIS | <input type="checkbox"/> YES <input type="checkbox"/> NO | THYROID DISORDER | <input type="checkbox"/> YES <input type="checkbox"/> NO |

CIRCLE ANY CONDITION WHICH YOU ARE CONCERNED ABOUT FOR YOUR HEALTH. LIST ANY OTHER CONDITION WHICH YOU ARE CONCERNED ABOUT FOR YOUR HEALTH. _____

CIRCLE ANY CONDITION YOU HAVE OR HAVE EVER HAD:

ANY EYE DISEASE, INJURY OR IMPAIRED SIGHT? _____
EAR DISEASE, INJURY OR IMPAIRED HEARING? _____
ANY TROUBLE WITH NOSE, SINUS, MOUTH OR THROAT? _____
FAINTING SPELLS, EPILEPSY OR LOSS OF CONSCIOUSNESS? _____
CONVULSIONS, PARALYSIS, DIZZINESS, OR HEADACHES? _____
DEPRESSION, ANXIETY OR HALLUCINATIONS? _____
ENLARGED GLANDS OR GLAND DISORDERS OR DIABETES? _____
SKIN DISEASE? _____
SHORTNESS OF BREATH OR LUNG PROBLEM? _____
CHEST PAIN, ANGINA PECTORIS OR HEART DISEASE? _____
SWELLING OF THE HANDS, FEET OR ANKLES? _____
VARICOSE VEINS? _____
EXTREME FATIGUE? _____
KIDNEY STONES? _____
BLADDER DISEASE? _____
ABNORMAL THIRST OR FREQUENT URINATION? _____
STOMACH TROUBLE OR ULCER? _____
INDIGESTION OR REFLUX? _____
LIVER OR GALL BLADDER DISEASE? _____
COLITIS OR BOWEL DISEASE? _____
HEMORRHOIDS OR RECTAL BLEEDING? _____
CONSTIPATION OR DIARRHEA? _____
CANCER? _____
HIGH CHOLESTEROL? _____
BONE OR JOINT DISEASE, ARTHRITIS? _____
VENEREAL DISEASE? _____
ANEMIA OR BRUISE EASILY? _____
MEN: PROBLEMS WITH PENIS OR TESTICLES? _____
WOMEN: PROBLEMS WITH VAGINA, UTERUS, OR OVARIES? _____
BREAST LUMPS OR DISCHARGE? _____
DO YOU HAVE A PROBLEM WITH SEXUAL FUNCTIONING OR RESPONSE? _____
HAVE YOU BEEN PHYSICALLY, EMOTIONALLY, OR SEXUALLY ABUSED (PAST OR PRESENT)? _____
ANYOTHER CONDITIONS NOT MENTIONED? _____
HAVE THERE BEEN ANY RECENT CHANGES IN:
APPETITE OR EATING? _____
BOWEL ACTION OR STOOL? _____

WEIGHT:

PRESENT WEIGHT? _____ LBS.
MAXIMUM WEIGHT? _____ LBS.
WHEN? _____

HABITS:

DO YOU WEAR A SEAT BELT IN THE CAR? _____ ALWAYS _____ SOMETIMES _____ NEVER
DO YOU EXERCISE? _____ YES _____ NO HOW OFTEN? _____
HOW DO YOU EXERCISE? _____
WHAT TIME DO YOU USUALLY GO TO SLEEP? _____ DO YOU SLEEP WELL? _____ YES _____ NO
AVERAGE HOURS OF SLEEP? _____
YOUR BLOOD TYPE, IF KNOWN? _____

NUTRITIONAL INFORMATION
PLEASE FILL THE AMOUNT AND CIRCLE DAY OR WEEK

MILK	_____	GLASSES PER DAY/WEEK	WHOLE MILK/SKIM/LOW FAT	
CHEESE	_____	SLICES PER DAY/WEEK		
YOGURT	_____	OZ. PER DAY/WEEK	PLAIN/FLAVORED	
ICE CREAM	_____	CUPS PER WEEK		
EGGS	_____	NUMBER PER WEEK		
RED MEAT	_____	SERVINGS PER DAY/WEEK		SUPPLEMENT:(VITAMINS,MINERALS)
POULTRY	_____	SERVINGS PER DAY/WEEK		1. _____
SEAFOOD	_____	SERVINGS PER DAY/WEEK		2. _____
COOKED VEGETABLES	_____	SERVINGS PER DAY/WEEK		3. _____
SALAD	_____	SERVINGS PER DAY/WEEK		4. _____
RICE	_____	SERVINGS PER DAY/WEEK		5. _____
WHOLE GRAINS	_____	SERVINGS PER DAY/WEEK		6. _____
POTATOES	_____	SERVINGS PER DAY/WEEK		7. _____
PASTA	_____	SERVINGS PER DAY/WEEK		8. _____
BEANS	_____	SERVINGS PER DAY/WEEK		9. _____
FRUITS	_____	SERVINGS PER DAY/WEEK		10. _____
SWEETS	_____	SERVINGS PER DAY/WEEK		
COFFEE	_____	CUPS PER DAY/WEEK		
TEA	_____	CUPS PER DAY/WEEK		
FRUIT JUICE	_____	OZ. PER DAY/WEEK		
SODA	_____	OZ. PER DAY/WEEK		

MEDICATIONS:	NEVER	OCCASSIONALLY	FREQUENTLY	DAILY
LAXATIVES	_____	_____	_____	_____
VITAMINS	_____	_____	_____	_____
SEDATIVES	_____	_____	_____	_____
TRANQUILIZERS	_____	_____	_____	_____
SLEEPING PILLS	_____	_____	_____	_____
ASPIRIN	_____	_____	_____	_____
CORTISONE	_____	_____	_____	_____
THYROID	_____	_____	_____	_____

ANY OTHER OVER THE COUNTER MEDICATIONS? _____

WOMEN ONLY: MENSTRUAL HISTORY

AGE AT ONSET: _____ AGE AT MENOPAUSE _____ (IF MENOPAUSAL, SKOP TO PREGNANCIES)

REGULAR _____ YES _____ NO CYCLE LENGTH _____

USUAL DURATION OF FLOW: _____ DAYS

FLOW: _____ HEAVY _____ MEDIUM _____ LIGHT PAIN OR CRAMPS _____ YES _____ NO

DATE OF LAST PERIOD: _____

DO YOU GET MOODY OR IRRITABLE BEFORE OR WITH PERIODS? _____ YES _____ NO

PREGNANCIES:

HOW MANY CHILDREN BORN ALIVE? _____ STILLBIRTHS: _____ PREMATURE: _____

CESAREAN SECTIONS: _____

ANY COMPLICATIONS WITH PREGNANCY? _____ YES _____ NO

HAVE YOU EVER HAD AN ABORTION? _____ YES _____ NO

HAVE YOU EVER HAD ANY ABNORMAL PAP SMEAR? _____ YES _____ NO

DATE OF LAST PAP? _____ / _____ / _____

HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM? _____ YES _____ NO

DATE OF LAST MAMMOGRAM: _____ / _____ / _____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM. PLEASE GIVE IT TO THE RECEPTIONIST OR NURSE.

NP3/04