The Sternberg Clinic

Please fill out the information below to the best of your ability

Name: ______________________________________ Birthdate: ____________________ Age:____ Today's Date: ____________________

What name would you prefer to be called? ____

What is the reason for your visit today? ____

MEDICAL HISTORY

Primary Care Physician (include address if not local) ____

Who referred you to our practice? _________________________ Same as above

Please list other physicians you wish reports sent to ____

(Mark all that apply)

Anemia
Arthritis
Asthma
Bleeding/Blood Disorder
Crohns Disease
Depression
Diabetes
Emphysema
Epilepsy/Seizures
Glaucoma
Heart Problems (type __________)
Hepatitis
High Blood Pressure
High Cholesterol or lipids
HIV/AIDS
Irritable Bowel Syndrome (IBS)
Immune Disorder
Kidney Disease
Liver Disease (type ____________)
Pneumonia/Bronchitis
Stomach Ulcer/Acid Reflux
Stroke
Thyroid Disease
Tuberculosis
Ulcerative Colitis
Other ______________________

Please list all of your previous operations and the approximate date (use back side of paper if needed):

1. ____ Date: ________________________________
2. ____ Date: ________________________________
3. ____ Date: ________________________________

Have you ever had problems with anesthesia? No Yes Explain: ____

Do you have a **pacemaker**, **defibrillator**, or **port**? No Yes

MEDICATIONS

If you don't take any medications, check this box:

Please list the medications (including over the counter) you take regularly and why you're taking it:

1. ___________________________ Reason ______________
2. ___________________________ Reason ______________
3. ___________________________ Reason ______________
4. ___________________________ Reason ______________
5. ___________________________ Reason ______________
6. ___________________________ Reason ______________
7. ___________________________ Reason ______________
8. ___________________________ Reason ______________
9. ___________________________ Reason ______________
10. ___________________________ Reason ______________
11. ___________________________ Reason ______________
12. ___________________________ Reason ______________

If you take a blood thinning medication, which one do you take?
Aspirin, Coumadin, Warfarin, Plavix, Pradaxa, Xarelto, Aggrenox, or other ____

ALLERGIES

If you don't have any known drug allergies, check this box:

Please list the medications that you are allergic to:

1. ______________________________ Reaction ______________________________

2. ______________________________ Reaction ______________________________

3. ______________________________ Reaction ______________________________

4. ______________________________ Reaction ______________________________

Do you have a latex allergy? No Yes
Are you allergic to iodine or shellfish? No Yes

SOCIAL HISTORY

Marital Status	Single	Married	Widowed	Divorced	Domestic Partner	Decline to answer
Use of Alcohol	Never	Rarely	Moderate	Daily, _______ drinks per day		
Use of Tobacco	Never	Previously, but quit: _________________		Current, packs/day: ________________________		
Use of Illicit Drugs	Never	Type/Frequency: ____________________		Decline to answer		

FAMILY MEDICAL HISTORY

Has anyone in your family had cancer No Yes

Type of cancer ____________________ Relationship to you ____________________ Age diagnosed ______________

Type of cancer ____________________ Relationship to you ____________________ Age diagnosed ______________

Type of cancer ____________________ Relationship to you ____________________ Age diagnosed ______________

Name: ________________________________ Birthdate: ____________________ Today's Date: ____________________

REVIEWS OF SYSTEMS (ROS)

Please only check the boxes only if they are bothering you TODAY

CONSTITUTIONAL SYMPTOMS
- Good General Health
- Recent Weight Change
- Fever/Sweats
- Fatigue
- Headache

SKIN
- Rashes
- Psoriasis
- Bruise Easily
- Abnormal Lumps
- *No symptoms*

NOSE
- Sinus Problems
- Breathing Problems
- *No symptoms*

CARDIOVASCULAR
- Palpitations
- Heart Murmur
- Chest Pain
- Irregular Heartbeat
- *No symptoms*

EARS
- Decreased Hearing
- Ringing in Ears
- *No symptoms*

GENITOURINARY
- Blood in Urine
- Frequency of Urination
- Painful Urination
- Loss of Bladder Control
- Enlarged Prostate
- *No symptoms*

GASTROINTESTINAL
- Nausea/Vomiting
- Constipation
- Diarrhea
- Blood in Stool
- Loss of Bowel Control
- *No symptoms*

ENDOCRINE
- Excessive Thirst/Appetite
- *No symptoms*

NEUROLOGIC
- Headache/Migraine
- Dizziness
- *No symptoms*

EYES
- Visual Loss
- Double Vision
- Painful Eyes
- *No symptoms*

THROAT
- Sore Throat
- Hoarseness
- Snoring
- *No symptoms*

RESPIRATORY
- Shortness of Breath
- Wheezing
- Cough
- *No symptoms*

MUSCULOSKELETAL
- Fractures/Sprains
- Osteoporosis
- Joint Swelling
- *No symptoms*

OTHER

Pregnant: _______ weeks

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Reviewed by: ____ Date: ______________________________

MEDICAL ASSISTANTS USE ONLY

Ht: _______________ Wt: _______________ BP: _______________ P: _______________ T: _______________

BMI: _____________