THE STERNBERG CLINIC

Patient Name:____ Today's Date: ____________________

Birthdate: _____________ Age:____ What name would you prefer to be called? _______________ Gender (Circle one): Male Female

Parent's Name (if patient is a minor):_______________________________________ Parent's DOB: ___/___/___

Address:_____________________________City:____________________________State:______Zip:________

Home Phone: ( )_____________ Work Phone: ( )_________________ Cell Phone: ( )_________________

Email:____ SSN#_________-______-_____________

Employed by:__________________________________ Occupation:__________________________________

Spouse's Name:_________________________ Spouse's DOB: ___/___/___ Occupation:____________________

Please provide the front desk with your ID & health insurance card so they may make a copy

Health Insurance ID#____ Customer Service Phone # _______________

Preferred Pharmacy: ________________________________ Pharmacy Phone: ( )______________________

In case of emergency call:__________________ Relationship: ____________ Phone Number: ( )____________

What is the reason for your visit today? ____

MEDICAL HISTORY

Primary Care Physician (include address if not local) ___________________________ Phone number: ( )_______________

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
☐ Crohn's Disease
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy/Seizures
☐ Glaucoma
☐ Heart Problems __________
☐ Heart Attack
☐ Hepatitis, type ___________
☐ 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

Name: ____ Birthdate: _____________________ Today's Date: ____________________

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 ______________ 7. __________________________ Reason ______________

2. __________________________ Reason ______________ 8. __________________________ Reason ______________

3. __________________________ Reason ______________ 9. __________________________ Reason ______________

4. __________________________ Reason ______________ 10.__________________________ Reason ______________

5. __________________________ Reason ______________ 11.__________________________ Reason ______________

6. __________________________ 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 If yes, what's your reaction ______________________________

Do you have an allergic reaction to adhesives/tapes? ☐ 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

Name: ____ Birthdate: _____________________ Today's Date: ____________________

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 ________________

Check (✓) if your blood relatives have ☐ Colon polyps ☐ Crohn's or ulcerative colitis ☐ Thyroid/Endocrine Problems

REVIEWS OF SYSTEM (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

____
____
____
____
____

Reviewed by: ____ Date: ______________________________

MEDICAL ASSISTANTS USE ONLY

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