DRS. HECHT, BASS, ROSEN and SCHWARTZ, P.A.

nephrology • dialysis • internal medicine

PATIENT INFORMATION

☐ Male ☐ Female

Name: _____ Employer: _____

Address: _____ Occupation: _____

City/State/Zip: _____ Work Phone #: ( ) _____

Birthdate: _____ Home Phone #: ( ) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Reason for Today's Visit:

Medical History

MEDICATIONS:

1. Non-Prescription - (✓ Any Taken Regularly)
   - ☐ vitamins
   - ☐ aspirin, bufferin
   - ☐ laxatives
   - ☐ antacids
   - ☐ decongestants
   - ☐ Tylenol
   - ☐ other: _____
2. Prescription - (including Birth Control Pills)

Medication	Dosage	#Times/ Day

IMMUNIZATIONS: (✓ Any Received)

- ☐ Measles
- ☐ German Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Hemophilus
- ☐ Pneumonia
- ☐ Hepatitis

☐ TB Skin Test: _____ (Year) Pos: ____ Neg: ____

☐ Tetanus Series: (Dates) _____

ALLERGIES: (✓ Any You Are Allergic To)

- ☐ Animals
- ☐ Demerol
- ☐ Penicillin
- ☐ Aspirin
- ☐ Grasses
- ☐ Pollens
- ☐ Codeine
- ☐ Insect Bites
- ☐ Sulfa

Of the following, are you allergic to:

Which Antibiotics? _____

Which Foods? _____

Which Sedatives? _____

☐ Other: _____

☐ No Known Allergies

HABITS:

Do you use tobacco? ☐ Yes ☐ No

☐ Chew ☐ Smoke

If yes, what kind? _____

If yes, how much? _____

Do you drink alcohol?	☐ Yes ☐ No
Do you use drugs?	☐ Yes ☐ No
Do you drink caffeinated beverages?	☐ Yes ☐ No
Do you wear seat belts?	☐ Yes ☐ No
Do you sleep well?	☐ Yes ☐ No
Do you eat well?	☐ Yes ☐ No
Do you exercise regularly?	☐ Yes ☐ No
(Women) Examine breasts monthly?	☐ Yes ☐ No

Have you used narcotics/other addictive drugs? ☐ Yes ☐ No

Types: _____

Have you been exposed to chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or/work?

☐ Yes ☐ No How often? _____

Types: _____

Have you experienced any of the following?

- ☐ marriage difficulties
- ☐ job difficulties
- ☐ sexual difficulties
- ☐ sexual attack
- ☐ nervous breakdown
- ☐ sleep difficulties
- ☐ emotional problems
- ☐ depression

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List any hospital stays, including surgeries, starting with most recent:

	DATE	REASON	HOSPITAL
1.			
2.			
3.			

Have you ever received any blood transfusions? ☐ Yes ☐ No When? _____

Conditions

Check (✓) if you have, or ever had, any of the following conditions:

- ☐ unexpected weight change of more than 10 lbs. in the past year
- ☐ serious problems with eyes or ears
- ☐ persistent swollen glands/unusual lumps
- ☐ breast lump or unusual discharge
- ☐ irregular or fast heartbeat
- ☐ chest pain or tightness
- ☐ frequent swelling of ankles or legs
- ☐ unusual or severe shortness of breath
- ☐ unusual skin problems or persistent sores
- ☐ redness, severe pain or swelling of joints
- ☐ frequent or severe back pain
- ☐ other: _____
- ☐ changes in appetite
- ☐ difficulty swallowing
- ☐ frequent or severe abdominal pain
- ☐ frequent nausea or vomiting
- ☐ frequent or severe constipation/diarrhea
- ☐ blood in a bowel movement
- ☐ black or tarry stools
- ☐ pain or burning with urination
- ☐ loss of control of urination
- ☐ frequent or severe headaches
- ☐ genital problems
- ☐ problems with pregnancy

Family History

Check (✓) if there is anyone in your immediate family with a history of:

- ☐ asthma
- ☐ birth defects
- ☐ bleeding problems
- ☐ cancer
- ☐ cystic fibrosis
- ☐ depression
- ☐ diabetes
- ☐ heart attack
- ☐ heart disease
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ mental retardation
- ☐ nervous breakdown
- ☐ seizures
- ☐ stroke
- ☐ thyroid problems

What questions do you wish to ask the doctor?

1. _____
2. _____
3. _____

Do you have a living will? ☐ Yes ☐ No

Signed: _____ Date: _____