Alan J Zend DO PLLC

PATIENT HISTORY FORM

Patient's Name: ____ Today's Date: ________________________________

Social Security Number: _________________________________ Date of Birth: _________________________________

Past Medical History
Previous Physician's name: ______________________________ Date of last exam: _____________________________

Have you ever been hospitalized? ☐Yes ☐No If yes, what for? ____

____

Have you ever been tested for hepatitis A, B or C? ☐Yes ☐No Which hepatitis virus?_________________________

Have you been vaccinated for hepatitis B? ☐Yes ☐No If yes, date vaccine series completed _____________

Have you been vaccinated for hepatitis A? ☐Yes ☐No If yes, date vaccine series completed _____________

Last Tuberculosis (TB) Screening? _________________________ Result of TB screening: ☐Positive ☐Negative

If positive TB screen, date of last chest x-ray: _________________ Result of chest x-ray: ☐Positive ☐Negative

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: __________________________________

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina ☐Shortness of breathe ☐Eye disorder / Glaucoma ☐Diabetes

☐High cholesterol ☐Asthma ☐Seizures ☐Kidney / Bladder problems

☐High blood pressure ☐Lung problems / cough ☐Stroke ☐Liver problems / Hepatitis

☐Low blood pressure ☐Sinus problems ☐Headaches / Migraines ☐Arthritis

☐Heartburn (reflux) ☐Seasonal allergies ☐Neurological problems ☐Cancer

☐Anemia or blood problems ☐Tonsillitis ☐Depression / Anxiety ☐Ulcers/colitis

☐Swollen ankles ☐Ear problems ☐Psychiatric care ☐Thyroid problems

Please describe any current or past medical treatment not listed above ______________________________________

____

____

Please list your past surgeries

____
_
____
_

Allergies

Are you allergic to penicillin or any other drugs? ☐Yes ☐No
Please list:

____

Medications
Please list:

____

____

PLEASE COMPLETE NEXT PAGE

Do you currently smoke or chew tobacco? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many packs per day? ________________________

Do you drink alcohol, beer, or wine? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many drinks per week? _______________________

Do you currently drink coffee and/or tea? ☐Yes ☐No If yes, how many cups per day? _________________________ Do you

exercise daily/weekly? ☐Yes ☐No

Do you use seatbelts while driving? ☐Yes ☐No Do you wear a helmet while riding a bike? ☐Yes ☐No

Family History

Living Age (or age at death) List serious illnesses

Mother ☐Yes ☐No _________________ ____

Father ☐Yes ☐No _________________ ____

Sisters ☐Yes ☐No _________________ ____

☐Yes ☐No _________________ ____

☐Yes ☐No _________________ ____

Brothers ☐Yes ☐No _________________ ____

☐Yes ☐No _________________ ____

☐Yes ☐No _________________ ____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness Which family member?

Anemia or Blood disease ____
Cancer ____
Diabetes ____
Glaucoma ____
Heart disease ____
High blood pressure ____
HIV disease / AIDS ____
Mental Illness / Depression ____
Stroke ____
Other serious illness ____

Females: Gynecological History

How many times have you been pregnant? ______________ Date of last Pap Smear: _____________________________

Have you had an abnormal Pap Smear? ☐Yes ☐No Diagnosis: _______________ Follow up: ______________

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: ____
Date of last mammogram: _____________________________ Mammogram results: _______________________________

Have you ever had a breast biopsy? ☐Yes ☐No Biopsy results: _____________________________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.
Patient/Legal Guardian Signature ____ Date ________________