

# Karen Sandler, D.O.

## PATIENT HISTORY FORM

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Phone number(s) where Dr. Sandler or her staff can leave messages containing sensitive medical information:

Phone number(s): (1) \_\_\_\_\_ (2) \_\_\_\_\_

Signature: \_\_\_\_\_

## Medications

*(List the names, dosages, and how often you take the drugs. Include over-the-counter vitamins, herbs, sleeping and diet pills, decongestants, steroids, Tylenol, Motrin, etc.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: *(To drugs or foods only)* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## List Approximate Dates and Results of Your Last:

	DATE	RESULTS
TB Skin Test	_____	_____
HIV Test	_____	_____
Chest X-Ray	_____	_____
Prostate Exam/PSA	_____	_____
Anal PAP Smear	_____	_____
Mammogram	_____	_____
Cervical PAP Smear	_____	_____
Colonoscopy	_____	_____
EKG	_____	_____
Bone Mineral Density	_____	_____
Dental Exam	_____	_____
Eye Exam	_____	_____
Blood Test	_____	_____
Last Physical Exam	_____	_____

## List Approximate Dates of Your Last:

Flu Vaccine \_\_\_\_\_ Tetanus Vaccine \_\_\_\_\_

Pneumococcal Vaccine \_\_\_\_\_ Hepatitis A Vaccine \_\_\_\_\_

Hepatitis B Vaccine \_\_\_\_\_

Other: \_\_\_\_\_

**Family Health History**

	NO	YES	WHO & AGE
Breast/Uterine/Ovarian Cancer?	_____	_____	_____
Colon Cancer?	_____	_____	_____
Any other types of cancer?	_____	_____	_____
Diabetes?	_____	_____	_____
Heart Attack or Heart Disease?	_____	_____	_____
High Blood Pressure or Cholesterol?	_____	_____	_____
Stroke?	_____	_____	_____
Alcoholism?	_____	_____	_____
Anxiety or Depression?	_____	_____	_____
Mental Illness?	_____	_____	_____
Alzheimer's Disease or Dementia?	_____	_____	_____
Epilepsy or Seizure?	_____	_____	_____
OTHER DISEASES THAT RUN IN YOUR FAMILY?	_____		
What country (countries) did your ancestors come from?	_____		

**Personal Health History? (Check all conditions you have or had *recently*)**

<b>General:</b>	___unintentional weight loss    ___weight gain    ___change of appetite    ___fever or chills ___recreational drug use    ___fatigue    ___alcoholism    ___frequent naps    ___increased thirst ___special diet    ___weakness    ___need assistance with activities of daily living Other: _____
<b>Ear, Nose, Throat &amp; Teeth:</b>	___recent infection    ___buzzing    ___hearing loss    ___goiter    ___chewing or swallowing problems ___nasal discharge    ___pain or pressure over sinuses    ___sneezing    ___hoarseness ___upper airway congestion    ___pain    ___ear wax    ___sore throat    ___dentures/bridges/plates ___bleeding gums    ___gingivitis    ___toothache Other: _____
<b>Eyes:</b>	___sensitive to bright light    ___pain in eye    ___change in vision    ___infection    ___itching ___reading glasses    ___blurred vision    ___double vision    ___glaucoma    ___cataract ___corrective lenses    ___spots/floaters    ___excessive tearing    ___redness    ___discharge Other: _____

<b>Lungs:</b>	__cough __tightness/pain in chest or lungs __shortness of breath __wheezing __coughing up phlegm __coughing up blood __night sweats __asthma __TB __pneumonia __bronchitis __emphysema __currently smoking/history of smoking __frequent colds or upper respiratory infections __cancer Other: _____
<b>Cardio-Vascular:</b>	__high blood pressure __chest pain/pressure/discomfort __fainting __dizziness __pacemaker __shortness of breath __cold sweats __irregular heart beats __numbness of left arm __heart attack __heart murmur __mitral valve prolapse __swelling of lower legs, ankles & feet __scarlet or rheumatic fever __leg cramps __high cholesterol __heart disease __attacks of shortness of breath at night __heart surgery __coldness, discoloration of extremities (hands/feet) __leg or chest pain associated with exercise __varicose veins __phlebitis Other: _____
<b>Gastro-Intestinal:</b>	__diarrhea __constipation __nausea __vomiting __bloating __flatulence __ulcers __intestinal pain __rectal bleeding __abdominal pain/cramping __heartburn/acid reflux __black stools __change in bowel habits __pain with bowel movements __hemorrhoids __liver disease/hepatitis __hernia __colitis __pancreatitis __gallstones __diverticulosis __cancer __surgery __irritable bowel syndrome Other: _____
<b>Urinary:</b>	__frequent urination __painful urination __excessive urination at night __urinary retention __bladder infection __dribbling/incontinence __blood in urine __kidney stones or disease __prolapsed bladder __bladder cancer Other: _____
<b>Skin &amp; Nails:</b>	__sores __rash __swelling __itching __lumps __changing moles __acne __open wound __excessive dryness, sweating, odor __herpes __warts __skin cancer __eczema __psoriasis __change in appearance, texture of nails __fungal infection of nails __brittleness, peeling, breaking of nails Other: _____
<b>Nervous System</b>	__headaches __migraines __weakness, numbness, or tingling of parts of body __dizziness __depression __convulsions __nervousness __insomnia __blacking out __stroke __gait imbalance __tic/tremor/spasm __currently in counseling/therapy __seizures __difficulty coping with stress __epilepsy __head injury Other: _____
<b>Endocrine:</b>	__diabetes __babies over 9 lbs. __hypoglycemia __thyroid disorder __adrenal disorders __goiter Other: _____

<b>Blood:</b>	__anemia __bleeding tendency __bruising __thalassemia __sickle cell anemia __leukemia __blood infection __blood transfusion(s): date & year _____ Other: _____
<b>Muscle &amp; Bones:</b>	__backache __joint pain __joint stiffness __joint swelling __muscle weakness __gout __osteoarthritis __rheumatoid arthritis __osteoporosis __surgery Other: _____
<b>Prostate/Genital</b>	__difficulty starting stream __difficulty stopping stream __erectile dysfunction __discharge __sores __swollen glands __lumps in scrotum Other: _____
<b>Breast:</b>	__nipple discharge __lumps, dimples __premenstrual tenderness __fibrocystic breasts __breast feeding __lumpectomy or mastectomy: right breast _____ left breast _____ __biopsy __cancer __breast self exam Other: _____
<b>Gynecologic:</b>	__irregular periods __painful periods __bleeding between periods __missed periods __painful intercourse __abnormal vaginal discharge __odor __syphilis __gonorrhea __uterine infection __vaginal infection __tubal ligation __tubal infection __condyloma __abnormal pap smear __sexual problems __fibroids __endometriosis __vaginitis __gardnerella vaginatis __herpes __trichomonas __menopausal __total hysterectomy __partial hysterectomy __hormone replacement therapy Other: _____
<b>Reproductive History:</b>	Total pregnancies: _____ # of abortions: _____ # of Deliveries: _____ # of miscarriages: _____ Age at onset of menses _____ Date of last pregnancy: _____ First day of last menstrual period: _____ How long do your periods last?: _____ What kind of flow do you have?: _____ How many days from one period to the next period?: _____ Do you use birth control methods?: _____Yes _____No _____Sometimes Present birth control method: _____ I need method: _____Yes _____No
<b>Methods Ever Used</b>	__birth control pills __foam __diaphragm __IUD __condoms __rhythm __withdrawal __Depo-Provera/progesterone shots __vasectomy __tubal ligation __cervical cap __none Other: _____
<b>Childhood Illnesses</b>	__chicken Pox __scarlet fever __polio Other: _____

<b>Past Surgeries and Dates</b>	<hr/> <hr/> <hr/> <hr/> <hr/>
<b>Past Hospitalizations and Dates</b>	<hr/> <hr/> <hr/> <hr/> <hr/>

**Have you had the following tests?**

	DATE	RESULTS
Rubella (German Measles)	_____	_____
Tay-Sachs Disease	_____	_____
Sickle Cell Anemia	_____	_____

<b>I Would Like To Discuss:</b>	<input type="checkbox"/> drug dependency <input type="checkbox"/> coping with stress <input type="checkbox"/> birth control <input type="checkbox"/> sexual problems <input type="checkbox"/> alcoholism <input type="checkbox"/> HIV Testing <input type="checkbox"/> sexually transmitted disease or exposure <input type="checkbox"/> weight loss <input type="checkbox"/> quitting tobacco smoking <input type="checkbox"/> living will or durable power of attorney for health care
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**Social History (please circle)**

1. Are you single, married, divorced, have a significant other, widowed? \_\_\_\_\_
2. What is your profession? \_\_\_\_\_
3. How many hours do your sleep at night? \_\_\_\_\_
4. How many caffeinated beverages do you drink at day? \_\_\_\_\_
5. Do you exercise on a regular basis? Yes - No
6. Any history of:
  - a. IV drug use? Yes - No
  - b. DUI's? Yes - No
  - c. Blackouts from drugs or alcohol? Yes - No
  - d. Street drug use? Yes - No
7. Have you ever been sexually active? Yes - No. If "yes", with men\_\_\_\_ women\_\_\_\_ both\_\_\_\_
8. Do you use condoms during intercourse? Yes - No.
9. Have you ever had unprotected intercourse? Yes - No
10. Have you ever had anal unprotected intercourse? Yes - No
11. Have you ever been treated for a sexually transmitted disease? Yes - No
  - a. Have you ever had venereal warts? Yes - No
  - b. Genital herpes? Yes - No
12. Have you ever or do you currently smoke or use any tobacco products? Yes - No
  - a. Packs per day? \_\_\_\_\_
  - b. Number of Years? \_\_\_\_\_
13. Are you exposed to second-hand smoke? Yes - No
14. Do you drink beer, wine, or hard liquor? Yes - No.
  - a. If, "yes", how often? Daily\_\_\_\_\_ Several times a week\_\_\_\_\_ Rarely\_\_\_\_\_

**Enclose copy of your Advanced Healthcare Directive & Durable Power of Attorney**