MARK A GREENFIELD, D.O., P.C.

MEDICAL HISTORY

NAME:	ADDRESS:	AGE:	SEX:

PATIENT HISTORY PLEASE CHECK IF YOU HAD:

☐ CANCER ☐ TB ☐ DIABETES ☐ BLOOD COTS ☐ MISCARRIAGES ☐ KIDNEY DISEASE ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ LUPUS ☐ THYROID DISEASE ☐ ARTHRITIS_____ (TYPE) ☐ RHEUMATIC FEVER ☐ BLEEDING DISORDERS ☐ GOUT ☐ ASTHMA

EXPLAIN:

PREVIOUS SURGERIES:

ALLERGIES TO MEDICATIONS: ☐ YES ☐ NO

IF YES, PLEASE LIST AND INCLUDE ADVERSE REACTION:

SOCIAL HSTORY NOW: ☐ SMOKING ☐ SUBSTANCE ABUSE ☐ ALCOHOL

OCCUPATION:

CURRENT MEDICATIONS:

HEIGHT:	WEIGHT:	HAIR COLOR:	EYE COLOR:	DO YOU WEAR: ☐ GLASSES ☐ DENTURES ☐ CONTACTS

GENERAL REVIEW

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE NOW:

☐ FREQUENT HEADACHES
☐ ANEMIA
☐ FREQUENT FEVER
☐ NIGHT SWEATS
☐ LOSS OF HAIR
☐ POOR APPETITE
☐ SKIN RASH
☐ WEIGHT LOSS_____ (LBS)
☐ VOMITTING
☐ JAUNDICE

☐ COLOR CHANGES IN FINGERS
☐ DIARRHEA
☐ SORES IN NOSE
☐ BLOOD IN STOOLS
☐ "BLACK TAR" STOOLS
☐ MORNING STIFFNESS_____ (DURATION)
☐ FREQUENT URINATION
☐ BLOOD IN URINE
☐ URINE BURNING
☐ LOSS OF BLADDER CONTROL

☐ SHORTNESS OF BREATH
☐ CHEST PAIN
☐ SWELLING
☐ BACK PAIN
☐ DIZZINESS
☐ EXCESSIVE COUGHING
☐ COUGHING W/BLOOD OR SPUTUM
☐ CHANGE OF VISION
☐ DRY EYES
☐ DRY MOUTH

☐ NUMBNESS
☐ DIFFICULTY IN SWALLOWING
☐ PASSING OUT
☐ CONVULSIONS
☐ MUSCLE WEAKNESS
☐ PARALYSIS
☐ JOINT PAIN
☐ JOINT SWELLING/TENDERNESS

PLEASE EXPLAIN IF CHECKED:

FAMILY HISTORY:

☐ CANCER ☐ TB ☐ DIABETES ☐ OSTEOPOROSIS ☐ KIDNEY DISEASE ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ THYROID DISEASE ☐ ARTHRITIS ☐ RHEUMATIC FEVER ☐ BACK PROBLEMS ☐ SCARLET FEVER ☐ BLEEDING DISORDERS ☐ GOUT ☐ ASTHMA