

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? _____ Please list other physicians you wish reports sent to _____
 Same as above

(Mark all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems _____ | <input type="checkbox"/> Liver Disease (type _____) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia/Bronchitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis, type _____ | <input type="checkbox"/> Stomach Ulcer/Acid Reflux |
| <input type="checkbox"/> Bleeding/Blood Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High Cholesterol or lipids | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Glaucoma | | |

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

If yes, what is the Manufacturer's Name: _____, Model Number: _____

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 _____ | 2. _____ | Reason _____ |
| 3. _____ | Reason _____ | 4. _____ | Reason _____ |
| 5. _____ | Reason _____ | 6. _____ | Reason _____ |
| 7. _____ | Reason _____ | 8. _____ | Reason _____ |
| 9. _____ | Reason _____ | 10. _____ | Reason _____ |
| 11. _____ | 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

Do you have an allergic reaction to adhesives/tapes? No Yes

Are you allergic to iodine or shellfish? No Yes

If yes, what's your reaction _____

Yes

SOCIAL HISTORY

Marital Status Single Married Widowed Divorced Domestic Partner

Decline to answer

Sexual Orientation Heterosexual Homosexual Bisexual 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

Do you engage in anal-receptive intercourse? No Yes 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 SYSTEMS (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: _____