Emilia E. Murray, MD- Medical Information Sheet

Patients Name ______________________________ Date of Birth ______________________

Today's Date ________________ Reason for todays visit __________________________

1.) History of Previous Surgeries: ☐ Yes (see the list below) ☐ No Previous Surgeries

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2.) Past Medical History: ☐ Yes (see the list below) ☐ No Past Medical Problems

☐ Hypertension ☐ Diabetes ☐ High cholesterol ☐Kidney disease ☐Heart attack ☐Heart disease
☐Stroke ☐Vascular disease ☐Cancer ☐Liver disease ☐Neurological disorders ☐Ulcers ☐Arthritis

Other medical problems ____

3.) Family Medical History: ☐Yes (see the list below) ☐No History of Family Medical Problems

Mother ☐Hypertension ☐Diabetes ☐Heart disease ☐Cancer Type:__________☐Arthritis
Father ☐Hypertension ☐Diabetes ☐Heart disease ☐Cancer Type: __________☐Arthritis
Siblings ☐Hypertension ☐Diabetes ☐Heart disease ☐Cancer Type: __________☐Arthritis
Other ____

4.) Social History:
Smoking: ☐Current every day smoker ☐Current some day smoker ☐former smoker ☐never smoked
Alcohol: ☐None ☐1 per day ☐2-3 per day ☐4 or more
Special diet: ☐Yes ☐No
Exercise: ☐Yes ☐No
Recreational Drug Use: ☐ Yes ☐No

5.) Do you have any allergies? ☐Yes (see the list below) ☐No known allergies

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6.) List any medications you are currently taking:

Name: Name: Name: Name:
____
Dose: Dose: Dose: Dose:
____
Qty per day: Qty per day: Qty per day: Qty per day:
____

7.) Date of your last physical exam & name of physician who saw you.

Physician ____________________ Month:____________ Year:____________

8.) (Women only) enter the date of your last PAP SMEAR exam & the physician.

Physician: ______________________________ Month:________ Year:________ Last Pap:__________
Have you had an abnormal pap? __________________ Biopsy? ____________________

9.) (Men only) enter date of your last urological exam & the physician.

Physician: ____________________________ Month:__________ Year: ____________ Last PSA:___________

10.) Have you ever had any allergic/ anaphylactic reaction?
(Turning red, overall swelling, difficulty breathing?) Yes No

If yes please explain: ____

11.) Preventive:

Last Mammo: _______________
Last Colonoscopy: ___________________
Last Tetanus:______________________
Last Bone Density/ Scan:_____________________
Last pneumonia Vaccine: _____________________
Flu Vac: ________________________________