Robert S. Enelow, M.D., F.A.C.P.

Medical History

Date: ____ / ____ / ____

Name ______________________ Age____ Birthdate___/___/___

Address ______________________ Sex: ☐ M ☐ F

______________________ Home phone ______________ Cell Phone ______________

______________________ Work Phone ______________________

Occupation ______________________ Emergency contact ______________________

Phone ______________________

☐ Single ☐ Married ☐ Divorced ☐ Widowed Email address ______________________

If married, spouse's name ______________________

Children's ages ______________________

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction):

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

Past Medical History & Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistant cough
16. Hay fever
17. Abdominal discomfort
18. Indigestion
19. Nausea
20. Vomiting
21. Constipation
22. Diarrhea
23. Blood in stool
24. Ulcers
25. Change in bowel habits
26. Unexplained weight gain/loss
27. Hemorrhoids
28. Gall Bladder disease
29. Colitis
30. Hepatitis or jaundice
31. Thyroid disease
32. Head or neck radiation
33. Headache
34. Kidney diseases
35. Kidney stones
36. Difficulty urinating
37. Arthritis
38. Low back problems
39. Skin diseases
40. Blood clots
41. Sexually transmitted illness
42. Anxiety
43. Depression
44. Anemia
45. Alcohol abuse
46. Drug abuse
47. Gout
48. ______________
49. ______________
50. ______________

Names of other Doctors/Specialists

____

____

____

____

____

____

Gynecologic and Obstetric History

Age at onset of periods: ____________ Frequency: ____________ Length of period: ____________

Pregnancies: ____________ Births: ____________ Miscarriages: ____________

Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe): ____________

Leakage of urine: ☐ No ☐ Yes (Please describe): ____________

Pelvic pain: ☐ No ☐ Yes (Please describe): ____________

Abnormal discharge: ☐ No ☐ Yes (Please describe): ____________

History of abnormal Pap smear: ☐ No ☐ Yes (Type of treatment): ____________

Patient Name Date: / /

Please List and Supply the Dates of:

Operations: ______ ______ ______

Hospitalizations other than for surgery: ______ ______ ______

Immunizations history—have you had:

Tetanus/Tdap? ☐ No ☐ Yes When?______

Prevnar vaccine? ☐ No ☐ Yes When?______

Pneumovax immunization? ☐ No ☐ Yes When?______

Flu immunization? ☐ No ☐ Yes When?______

Shingles/Zostavax/Shingrix? ☐ No ☐ Yes When?______

When was your last:

Pap smear? ______ Colonoscopy? ______ Mammogram? ______

Prostate exam? ______

Family History

Has any member of your family (including parents, grandparents, and sibling) ever had the following?

Illness	Which family members?	Approx age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Anxiety, depression		
Substance or alcohol abuse		
Thyroid disease		
Blood clots		
Other: ______		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug name	Dose	Drug name	Dose

Prevention

Do you wear seatbelts? ☐ No ☐ Yes If no, why not? ______

Do you smoke, or did you used to smoke? ☐ No ☐ Yes If yes, how many packs per day? ______

Do you drink alcoholic beverages? ☐ No ☐ Yes If yes, how much per week?______

If there is a gun in your home, is it out of children's reach and unloaded? ☐ No ☐ Yes ☐ N/A

Do you use drugs? (marijuana, cocaine, etc..) ☐ No ☐ Yes If yes, explain: ______

Have you ever engaged in any sex activity which has put you at risk of getting AIDS? ☐ No ☐ Yes If yes, explain: ______

Do you wish to be tested for AIDS? ☐ No ☐ Yes

Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes

Do you ever feel afraid of your partner? ☐ No ☐ Yes

Do you have an Advanced Medical Directive? ☐ No ☐ Yes

Method of birth control?______