Medical History

Date: / /

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

Name _____ Age_____ Birthdate____/____/____

Address_____ Sex: Male Female

_____ Home Phone _____ Cell Phone_____

_____ Work Phone _____

Occupation_____ Email _____

Emergency Contact _____

Single Married Divorced Separated Divorced Phone_____

_

If married, spouse's name _____

Children's ages _____

Allergies to Medications, Xray 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. Asthma
12. Bronchitis
13. Pneumonia
14. Persistent cough
15. Hay fever
16. Abdominal pain/ discomfort
17. Indigestion
18. Nausea
19. Vomiting
20. Constipation
21. Diarrhea
22. Blood in stool
23. Ulcers
24. Change in bowel Habits
25. Unexplained weight gain/loss
26. Hemorrhoids
27. Gall Bladder disease
28. Colitis
29. Hepatitis or jaundice
30. Thyroid disease
31. Headache
32. Kidney disease
33. Kidney stones
34. Difficulty urinating
35. Arthritis
36. Low back pain
37. Skin diseases
38. Blood Clots
39. Sexually transmitted diseases
40. Anxiety
41. Depression
42. Anemia
43. Alcohol abuse
44. Drug abuse
45. Gout
48. Covid
49. _____
50. _____
51. _____

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 (Please describe): _____

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

Immunization history–have you had:

Tetanus/TdaP? No Yes When? _____

Prevnar vaccine? No Yes When? _____

Covid vaccine? No Yes Which one? Pfizer Moderna J&J Other

Dates Administered? _____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Pneumovax Immunization? No Yes When? _____

Flu Immunization? No Yes When? _____

Shingrix (Shingles) vaccine? No Yes When? _____

Gyn Exam? _____ Colonoscopy? _____ Mammogram? _____ Prostate exam? _____

Family History

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

Illness	Which family members?	Approx age when diagnosed
Cancer (describe type)		
High blood pressure		
Heart disease		
Diabetes		
Strokes		
Anxiety, Depression		
Substance or Alcohol abuse		
Thyroid disease		
Blood clots		

Other: _____

Medications (Prescription, OTC, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Prevention

Do you smoke, or did you used to smoke?	No	Yes	If yes, how may pack per days? _____
Do you drink alcoholic beverages?	No	Yes	If yes, how much per week? _____
If there is a gun in your home, is in a safe place?	No	Yes	N/A
Do you use illicit drugs?	No	Yes	N/A
Do you wish to be tested for HIV?	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?	No	Yes	