

**Stuart Glassman, M.D., F.A.C.S.**

**MEDICAL HISTORY FORM**

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Reason for visit (why are you here?) \_\_\_\_\_

Regular Medical Doctor \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

List **ALL** medicines and dosages (include all over-the-counter medicines, herbals, supplements and vitamins).

\_\_\_\_\_  
\_\_\_\_\_

Do you take a blood thinner? \_\_\_\_\_

List **ANY** and **ALL** allergies (include allergies to local or general anesthetics or tape)

\_\_\_\_\_

**Family History** - List major medical conditions (heart disease, strokes, Cancers, diabetes, bleeding problems)

\_\_\_\_\_

Your Personal Past Medical History: Have you ever had any of the following conditions?

- High blood pressure (hypertension).....No \_\_\_\_\_ Yes \_\_\_\_\_
- Heart disease (angina, heart attack, valve problems).....No \_\_\_\_\_ Yes \_\_\_\_\_
- CANCER of any kind..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Diabetes (requiring pills or insulin).....No \_\_\_\_\_ Yes \_\_\_\_\_
- High Cholesterol? When was it last checked?.....No \_\_\_\_\_ Yes \_\_\_\_\_
- Epilepsy (seizure disorder) Strokes or TIA's.....No \_\_\_\_\_ Yes \_\_\_\_\_
- Lung disease (asthma, bronchitis, emphysema,TB).....No \_\_\_\_\_ Yes \_\_\_\_\_
- Kidney disease (stones, infections, tumors).....No \_\_\_\_\_ Yes \_\_\_\_\_
- Thyroid conditions..... No \_\_\_\_\_ Yes \_\_\_\_\_
- Mental health or psychiatric problems.....No \_\_\_\_\_ Yes \_\_\_\_\_
- Skin conditions (cancers, psoriasis, ulcers).....No \_\_\_\_\_ Yes \_\_\_\_\_
- Stomach ulcers or reflux (GERD, heartburn).....No \_\_\_\_\_ Yes \_\_\_\_\_
- Liver disease (cirrhosis, hepatitis, jaundice).....No \_\_\_\_\_ Yes \_\_\_\_\_
- Any bleeding or clotting problems ("free-bleeder").....No \_\_\_\_\_ Yes \_\_\_\_\_
- Any significant weight loss or gain recently?.....No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you have any hernias?.....No \_\_\_\_\_ Yes \_\_\_\_\_
- Have you had any exposure to AIDS (HIV)?.....No \_\_\_\_\_ Yes \_\_\_\_\_
- ARE YOU PREGNANT?.....No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you have swollen or aching legs or leg ulcers?.....No \_\_\_\_\_ Yes \_\_\_\_\_
- Do you have varicose vein problems?.....No \_\_\_\_\_ Yes \_\_\_\_\_

List **ANY** and **ALL** surgical procedures and approximate dates: \_\_\_\_\_

\_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ Do you drink? (how much) \_\_\_\_\_

Do you use any other tobacco products? (What) \_\_\_\_\_

Approximate height \_\_\_\_\_ Approximate weight \_\_\_\_\_