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 _____