Dr. Stephen S. Rodrigues, M.D.

PATIENT HISTORY

Name: Date: Age:
Reason for visit:
PAST MEDICAL PROBLEMS:
Have you had any of the following surgeries? (Please check): ___ appendectomy, ___ tonsillectomy, ___ hysterectomy,
___ hernia surgery, ___ cosmetic surgeries, ___ gallbladder surgery, ___ heart bypass, ___ angioplasty
Please list all of your other current doctors:

CONDITIONS Check conditions that you have had or are having

	AIDS/HIV Positive		Emphysema		Multiple Sclerosis
	Alcoholism		Epilepsy/Seizures		Pacemaker
	Anemia		Glaucoma		Pneumonia
	Anorexia		Goiter		Polio/Mumps/Chicken Pox
	Appendicitis		Gout		Prostate Problems
	Arthritis		Heart Disease		Psychiatric Care
	Asthma		Hepatitis		Rheumatic Fever
	Bleeding Disorder		Hernia: Inguinal/Hiatal		Stroke
	Bronchitis		Herpes		Suicide Attempt
	Bulimia		High Blood Pressure		Thyroid Problems
	Cancer		High Cholesterol		Tuberculosis
	Cataracts		Kidney Disease		Ulcers
	Chemical Dependency		Liver Disease		Sexually Transmitted Disease
	Depression		Migraine Headaches		Other:
	Diabetes		Mitral Valve Prolapse		

ALLERGIES/ADVERSE REACTION (Medicine, Food, etc.) _____

_____

MEDICATIONS: Please include over-the-counter products

NAME	DOSE	HOW OFTEN?

Are you taking Vitamins?

_____

Alternative Medicine/Herbs

_____

_____

HEALTH HABITS	None	How Much?	How often?	How long?	When quit?
Tobacco					
Alcohol					
Illicit Drugs					
Coffee					

SOCIAL HISTORY

Occupation _____ Marital Status _____

Education Level _____ With whom do you live _____

FAMILY HISTORY:	Significant Medical Conditions	Age	If applicable, cause of death
Father			
Mother			
Brothers			
Sisters			

Is there any history of the following in your extended family? (Please check)

	High Blood Pressure		Heart Disease		Cancer		Blood Disorders
	Diabetes		Lung Disease		Anemia		Asthma/ Allergies
	Stroke		Kidney Disease		Arthritis		Psychiatric Disorders

SYMPTOMS (Please select yes or no for each one)

General	No	Yes
Chills/Fever		
Depression		
Fainting/Dizziness		
Loss of weight		
Sweating		
Difficultly sleeping		
Decrease energy		
EYES/EARS/NOSE/THROAT		
Blurred vision		
Double vision		
Eye pain		
Decreased hearing		
Ring in ears		
Earache		
Runny nose		
Sinus problems		
Mouth ulcers		
Persistent cough		
CARDIVASCULAR		
Chest pain		
HBP		
Shortness of breath		
Irregular heartbeats		
Palpitations		
Swollen ankles		
Leg cramps		
Heart murmur		
Heart Problems		

	No	Yes
Asthma		
GASTROINTESTINAL		
Poor appetite		
Trouble swallowing		
Pain with swallowing		
Indigestion		
Heartburn		
Nausea		
Vomiting		
Bloating		
Abdominal pain		
Diarrhea		
Ulcer disease		
Liver disease		
Hepatitis history		
Gallbladder disease		
Lactose intolerance		
Hemorrhoid history		
Blood stool		
Abdominal swelling		
Jaundice (yellow eyes)		
Constipated		
Using laxatives		
Loss of bowel control		
RESPRIATORY		
Coughing		
Coughing up blood		
Tuberculosis		

MUSCULOSKELETAL		
Swollen joints		
Coughing up blood		
Joint stiffness		
Muscle Pain		
Arthritis		
Back Pain		
Sweating often		
Skin rash		
Itching		
Reproductive (Women Only)	No	Yes
Date of last pap smear		
Ever had abnormal pap		
Last menstrual period		
Number of pregnancies		
Abortions or miscarriages		
Bleeding between periods		
Bleeding after menopause		
Severe PMS		
Painful periods		
Any current vaginal discharge		
Do you have painful intercourse		
Sexual dysfunction		
Could you be pregnant now		
Method of contraception		
Date of last mammogram		
Ever had abnormal mammo.		
Do you do breast self exams		
NEUROLOGICAL		
Have you ever had a seizure		
Ever had loss of consciousness		
Ever had a head injury		
Ever had a stroke		
Paralysis or weakness		

GENITOURINARY		
Trouble urinating		
Blood in urine		
Freq. urination		
Loss of bladder control		
Reproductive (Men Only)		
Prostate Problems		
Discharge from penis		
Lumps or pain in testicles		
Sexual dysfunction		
MOOD AND STRESS	No	Yes
Do you have trouble falling asleep		
Trouble staying asleep		
Confused episodes		
Personality changes		
Episodes of depression		
Any sadness or crying spells		
Any past psychiatric care		
ENDOCRINE		
Thyroid problems		
Diabetes		
Ever used hormones		
INFECTIOUS DISEASES		
Ever had sexual transmitted disease		
Ever had blood transfusion		
Have you traveled out the country lately		
Have you been camping lately		
Have you been hunting recently		
TRAUMA		
Have you ever been in a major accident		
Ever been exposed to toxic chemicals		
History of radiation or microwave exposure		
Do you always wear a seat belt		