NINA J. PAONESSA, D.O., F.A.C.O.S.

Today's Date:_____

Name:_____ **Date of Birth**:_____

Primary Care Physician: _____ **Referring Physician:** _____

Other Treating Physicians:_____

ALLERGIES:
Please list all medications, latex, dyes, foods, etc.

Allergy List	Reaction

MEDICATIONS:
Please list all medications or drugs including over the counter medications, herbal supplements and vitamins

Drug /Medicine	Amount/Dose	Frequency

DO YOU HAVE OR HAVE YOU HAD: please circle Y or N

Y	N	HIV or AIDS	Y	N	Emphysema or COPD	Y	N	Organ Transplant
Y	N	Diabetes, Insulin Requiring	Y	N	Sleep Apnea	Y	N	Psoriasis or other skin disease
Y	N	Diabetes, Non-Insulin	Y	N	Pneumonia	Y	N	Migraine Headaches
Y	N	Heart Attack	Y	N	Tuberculosis	Y	N	Seizure Disorder
Y	N	Coronary Artery Disease	Y	N	Hypothyroidism	Y	N	Psychiatric Disorder
Y	N	Heart Arrhythmia	Y	N	Hiatal Hernia/Reflux	Y	N	Anxiety Disorder
Y	N	Pacemaker	Y	N	Peptic Ulcer Disease	Y	N	Depression
Y	N	Defibrillator	Y	N	Diverticulitis	Y	N	Drug Addiction
Y	N	Coronary Stents	Y	N	Hepatitis	Y	N	Glaucoma
Y	N	Heart Murmur	Y	N	Liver Disease	Y	N	Leukemia / Lymphoma
Y	N	High Blood Pressure	Y	N	Urinary Tract Infections	Y	N	Cancer (list type)
Y	N	High Cholesterol	Y	N	Kidney Stones	**Please list other conditions not mentioned**		
Y	N	Stroke or Mini Stroke (TIA)	Y	N	Osteoporosis			
Y	N	Bleeding Disorder	Y	N	Fibromyalgia			
Y	N	Pulmonary Embolism	Y	N	Gout			
Y	N	Deep Vein Thrombosis	Y	N	Osteoarthritis			
Y	N	Peripheral Vascular Disease	Y	N	Rheumatoid Disease			
Y	N	Asthma	Y	N	Poliomyelitis			

Name: _____ **Date of Birth** _____

REVIEW OF SYSTEMS: Have you had any of the following?

HEAD / EARS / EYES
__Y__N Cataracts
__Y__N Recent Change in Vision
__Y__N Head Injury
__Y__N Ringing in the ears
__Y__N Hearing Loss
__Y__N Hearing Aid
Other: _____

NOSE / SINUSES
__Y__N Hay fever/seasonal allergy
__Y__N Frequent nose bleeds
Other: _____

SKIN
__Y__N Skin Cancer
__Y__N Itching
__Y__N Wound healing problems
Other: _____

MOUTH / THROAT
__Y__N Bleeding mouth/gums
__Y__N Difficulty Swallowing
__Y__N Dentures
Other: _____

CARDIAC
__Y__N Frequent chest pains
__Y__N Palpitations
__Y__N Atrial Fibrillation
__Y__N Infection of the heart
Other: _____

PULMONARY
__Y__N Shortness of breath
__Y__N Cough up blood
__Y__N Frequent coughing
__Y__N Wheezing
Other: _____

OB/GYN
__Y__N History of venereal disease
__Y__N Chance you may be pregnant
__Y__N Pregnancies #____Births#____
Last Menstrual period _____

BREAST
__Y__N Cancer
__Y__N Pain
__Y__N Masses/lumps
__Y__N Mammogram? When_____

GASTROINTESTINAL
__Y__N Abdominal pain/How long?_____
__Y__N Rectal Bleeding
__Y__N Change in bowel habits
__Y__N Constipation
__Y__N Diarrhea
__Y__N Hemorrhoids
__Y__N Rectal/anal pain, itching, burning
__Y__N Nausea/vomiting
__Y__N Change in appetite

UROLOGIC
__Y__N Increased frequency
__Y__N Dribbling
__Y__N Blood in urine
__Y__N Kidney stones
__Y__N Need to get up at night to urinate
How many times? _____
Other: _____

MUSCULOSKELETAL
__Y__N Joint pain
__Y__N Joint swelling
__Y__N Muscle disorder or problem
Other: _____

NEUROLOGIC
__Y__N Seizure disorder
__Y__N Fainting
__Y__N Numbness in arms or legs
__Y__N Paralysis

VASCULAR
__Y__N Aneurysm
__Y__N History of blood clots

ENDOCRINE
__Y__N Kidney Dialysis
__Y__N Diabetes

IMMUNE
__Y__N Blood transfusion
__Y__N Immunosuppression

SURGERY
__Y__N Problems with anesthesia?
What? _____
__Y__N Prolonged bleeding when cut
__Y__N Latex allergy

(FOR OFFICE USE ONLY)

UPDATED _____

UPDATED _____

UPDATED _____

UPDATED _____

All systems negative except as marked

_____
Physician Signature

_____
Date

Name: _____ **Date of Birth** _____

PAST SURGICAL HISTORY - Please list any operations you have had, approximate date or age at time of surgery

		Date / Age			Date / Age
__Y__N	Appendectomy	_____	__Y__N	Cholecystectomy/Gallbladder	_____
__Y__N	Hysterectomy	_____	__Y__N	Wisdom teeth extraction	_____
__Y__N	Hernia Repair	_____	__Y__N	Tonsils/Adenoids	_____
__Y__N	C-section	_____	__Y__N	Prostate	_____
__Y__N	Tubal ligation	_____	__Y__N	Rectal Surgery	_____

Please list any additional surgeries:

Operation	Date / Age
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

1. Marital Status __Single __Married __Divorced __Widowed __Living with significant other

2. Do you now or have you ever smoked or used smokeless tobacco? __Y__N
   If yes, how many packs per day _____ or how many tins/pouches _____ Cigars _____ How many years? _____
   If no, never smoked _____ Past smoker _____ How much did you smoke, when did you quit? _____

3. Do you drink? __Y__N
   If yes, _____ Drinks _____ Beers _____ Wine or Liquor servings per day
   _____ Social - weekly or weekends
   _____ Few times a year only
   _____ Alcoholism / Alcoholism abuse

FAMILY HISTORY - Please list any family members (parents, grandparents, siblings, and children) with any conditions:

__Y__N	Stroke	_____	__Y__N	Colon Polyps	_____
__Y__N	Heart Disease	_____	__Y__N	Colon Cancer	_____
__Y__N	Diabetes	_____	__Y__N	Diverticulitis	_____
__Y__N	Asthma	_____	__Y__N	Crohn's Disease	_____
__Y__N	High Blood Pressure	_____	__Y__N	Ulcerative Colitis	_____
CANCER:					
__Y__N	Breast	_____	__Y__N	Uterine	_____
__Y__N	Ovarian	_____	__Y__N	Stomach	_____
__Y__N	Prostate	_____	__Y__N	Other Cancer:	_____

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(FOR OFFICE USE ONLY)

UPDATED _____

UPDATED _____

UPDATED _____

UPDATED _____

All systems negative except as marked

_____
Physician Signature

_____
Date