

MICHAEL E. BUXBAUM, D.O. P.A. NEW PATIENT MEDICAL HISTORY

NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

SEX M F **MARITAL STATUS** S M W D SEP **PREGNANCY HISTORY** *Enter the number of:*
Times pregnant ___ Miscarriages _____ Living children ___

ALLERGIES to medications: None Penicillin Sulfa Codeine Other _____

LIST ALL MEDICATIONS YOU ARE NOW TAKING

| | | |
|----|----|-----|
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |

LIST ALL PRIOR HOSPITALIZATIONS AND SURGERIES

| | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

PERSONAL AND FAMILY ILLNESS

Check where you or members of your family have had the following illnesses or problems:

| You | Your Family | | You | Your Family | |
|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease / Hepatitis / Yellow jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease / Emphysema / Chronic Bronchitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Mumps, Measles / Chicken Pox |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer / Tumor | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Breakdown / Mental illness |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Phlebitis / Vasculitis / Blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Use/Abuse | <input type="checkbox"/> | <input type="checkbox"/> | Reflux / Gastritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression/anxiety | <input type="checkbox"/> | <input type="checkbox"/> | Rubella / German measles |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema / hives / rashes | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/seizures | <input type="checkbox"/> | <input type="checkbox"/> | Suicide attempt |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye problems | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer in stomach / duodenum |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Congestive Heart Failure |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | HIV + / AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney / Bladder problems | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |

HEALTH MAINTENANCE

| Vaccine | Year of Last | Test / Exam | Year of Last |
|-----------------|--------------|----------------|--------------|
| Tetanus / Td | | Rectal / Stool | |
| Influenza (FLU) | | PAP / Pelvic | |
| Pneumonia | | Mammogram | |
| Hepatitis | | Cholesterol | |
| Tuberculosis | | Eye | |

TOBACCO/ALCOHOL/DRUGS

Do you smoke? ___ Yes ___ No How many packs a day? _____ How many years? _____
 Do you drink alcohol? ___ Yes ___ No ___ Socially ___ Moderately ___ Excessively
 Do you use any street drugs? ___ Yes ___ No ___ I did in the past Type _____