

Fardad Mobin, MD
Patient Health History Form

Patient Name: _____ Age: _____ DOB _____

Name of Physician requesting this consultation: _____

Chief Complaint

Reason for today's visit? _____

Past History

Please list any prior major illnesses and/or injuries:

Surgeries/Hospitalizations	Year	Complications

Have you ever Had Problems with Anesthesia? Yes _____ No _____

Current Medications including Aspirin	Dose	Frequency

ALLERGIES/REACTIONS TO MEDICATIONS, ANESTHETICS OR MATERIAL:

Family History (circle one)

Do you have a family history of trouble with anesthesia? Yes No

Do you have a family history of easy bleeding? Yes No

Social History

Do you smoke? ___ Yes, I've smoked _____ packs of cigarettes per day for _____ years

___ Yes, I smoke Cigars or a Pipe.

___ No, I have never smoked.

___ No, I quit _____ years ago. At the time I was smoking _____ packs per day for _____ years

Do you drink alcohol? ___ No, never (or rarely) ___ No, but I used to

___ Yes ___ Daily ___ 1 or more times a week ___ 1 or more times a month

REVIEW OF SYSTEMS:

Are you currently, or have you had, problems with:

CONSTITUTIONAL	Circle One	
Weight Gain	YES	NO
Weight Loss	YES	NO
Night Sweats	YES	NO
Insomnia	YES	NO

EYES		
Double vision	YES	NO
Visual Loss	YES	NO

EAR, NOSE THROAT AND MOUTH		
Hearing Loss	YES	NO
Noise/Ringing in ears	YES	NO
Nasal Congestion	YES	NO
Nasal Drainage	YES	NO
Sore Throat	YES	NO
Trouble Swallowing	YES	NO
Hoarseness	YES	NO

CARDIOVASCULAR		
Chest Pain or Angina	YES	NO
Heart Trouble	YES	NO
Rheumatic Fever	YES	NO
Heart Murmur	YES	NO
High Blood Pressure	YES	NO

NEUROLOGICAL		
Numbness	YES	NO
Weakness	YES	NO
Stroke	YES	NO
Headache	YES	NO

PSYCHIATRIC		
Depression	YES	NO

ALLERGIC/IMMUNOLOGIC		
Sneezing	YES	NO
Itchy Eye/Nose	YES	NO
Itchy Throat	YES	NO
Skin Rash	YES	NO
HIV	YES	NO

I have reviewed the above information with the Patient.

RESPIRATORY	Circle One	
Asthma	YES	NO
Cough up Blood	YES	NO
TB	YES	NO
Pneumonia	YES	NO
Trouble Breathing At Night	YES	NO
Snoring	YES	NO

GASTROINTESTINAL		
Indigestion or Heartburn	YES	NO
Ulcer	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Blood In Stool	YES	NO
Black, Tarry Stools	YES	NO

GENITOURINARY		
Bladder Trouble	YES	NO
Prostate Disease	YES	NO
Kidney Disease	YES	NO

MUSCULOSKELETAL		
Arthritis	YES	NO

ENDOCRINE		
Diabetes	YES	NO
Thyroid Disease	YES	NO

HEMATOLOGIC		
Bleeding Disorder	YES	NO
Easy Bleeding	YES	NO

The above information is accurate to the best of my knowledge.

_____	_____
<i>Patient Signature</i>	<i>Date</i>

Physician Signature

Date