ARNOLD R. LEIBOFF, MD
NEW PATIENT MEDICAL HISTORY – GENERAL SURGERY

Name: _____

Age: _____ Date of Appointment: _____

Who were you referred by? _____

Who is your primary care physician? _____

Please name your other doctors. _____

What is your main complaint and reason for your visit? _____

_____

_____

PAST MEDICAL HISTORY

Please check YES or NO depending on whether or not you have had the condition.

Autoimmune disease ---------- ☐ **YES** ☐ **NO**

Blood transfusions ---------- ☐ **YES** ☐ **NO**

Bleeding disorder (for example, hemophilia) ---------- ☐ **YES** ☐ **NO**

If yes, describe: _____

Cancer ---------- ☐ **YES** ☐ **NO**

If yes, what type? _____

Chronic lung disease (asthma, emphysema, or bronchitis) ---------- ☐ **YES** ☐ **NO**

If yes, for how long? _____

Diabetes ---------- ☐ **YES** ☐ **NO**

If yes, for how long? _____

Gastroesophageal Reflux Disease (GERD) ---------- ☐ **YES** ☐ **NO**

Heart disease ---------- ☐ **YES** ☐ **NO**

If yes, describe and give dates. _____

Hepatitis or jaundice ---------- ☐ **YES** ☐ **NO**

Hypertension (high blood pressure) ---------- ☐ **YES** ☐ **NO**

Name: _____

Kidney problem ---------- ☐ **YES** ☐ **NO**

Pacemaker ---------- ☐ **YES** ☐ **NO**

Prostheses (for example, metal rods, screws or plates) ---------- ☐ **YES** ☐ **NO**

Neurological problem (for example, stroke, mini stroke) ---------- ☐ **YES** ☐ **NO**

If yes, describe: _____

Thyroid disease ---------- ☐ **YES** ☐ **NO**

Ulcers ---------- ☐ **YES** ☐ **NO**

Do you get chest pain, shortness of breath or heart palpitations? ---------- ☐ **YES** ☐ **NO**

Have you ever had any serious injuries, permanent scars or disability? ---------- ☐ **YES** ☐ **NO**

If yes, please describe. _____

_____

Please describe other medical illnesses that you have had, which are not mentioned above.

_____

_____

Please list all operations which you have had and the year of your surgery.

	Operation	**Year**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Obstetric and gynecological history (for women only):

How many times were you pregnant? _____

How many vaginal deliveries? _____ How many Caesarean sections? _____

When was your last menstrual period? _____

Name: _____

MEDICATIONS

Do you take any prescription medications? ---------- ☐ YES ☐ NO

If yes, please list your current medications and dosages.

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

Please list the non-prescription medications which you take (for example, aspirin or vitamins).

1. _____ 3. _____

2. _____ 4. _____

ALLERGIES AND SENSITIVITIES

Are you allergic to any medications? ---------- ☐ YES ☐ NO

If yes, please list the medications to which you are allergic and describe the reaction you had to each medication. _____

_____

Are you allergic to iodine, contrast agents, sea food or latex? ---------- ☐ YES ☐ NO

If yes, to which? _____

FAMILY HISTORY

List the significant illness of your grandparents. _____

_____

List the significant illnesses of your parents. _____

_____

Name: _____

List the significant illness of your brothers and sisters. _____

_____

_____

How many children do you or did you have? _____

Please list their illnesses. _____

SOCIAL HISTORY

Check one: You are ☐ employed ☐ unemployed ☐ retired ☐ disabled

What is or was your occupation? _____

Do you consume alcohol now? ---------- ☐ YES ☐ NO

If yes, what do you drink, how much and how often? _____

Were you a heavy drinker or alcoholic in the past? ---------- ☐ YES ☐ NO

Do you now or have you ever smoked? ---------- ☐ YES ☐ NO

If yes, please check which. ☐ Cigarettes ☐ cigars ☐ pipe

How many packs of cigarettes per day? _____ For how many years? _____

Do you still smoke? ---------- ☐ YES ☐ NO

If no, when did you quit? _____

Have you traveled outside of the United States in the last 3 years? ---------- ☐ YES ☐ NO

If yes, where to? _____