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EDWARD MURPHY, MD
PATIENT MEDICAL HISTORY FORM

PATIENT NAME____ DATE____________________

DATE OF BIRTH______/______/______ AGE_________WEIGHT__________ SEX: male / female

MARITAL STATUS: S M W D SEP N/A OCCUPATION________________________________

PRIMARY CARE PHYSICIAN:____

WHO REFERRED YOU TO OUR OFFICE?____

REASON FOR VISIT:____

ARE YOU *ALLERGIC* TO ANY MEDICATIONS? YES:_____NO:______IF YES PLEASE LIST:

1.____________________________**2.**____________________________**3.**___________________________

DO YOU SMOKE?___________NO___________YES HOW MUCH?_____________PACKS A DAY

DO YOU DRINK ALCOHOL?________NO__________YES HOW OFTEN?____________________

NUMBER OF SIBLINGS: ____________________ PARENTS:__________LIVING________DECEASED

LAST TETANUS:_________ DO YOU TAKE ANTIBIOTICS BEFORE PROCEDURES? ____N_____Y

LIST YOUR CURRENT MEDICATIONS AND DOSAGES:

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

HAVE YOU HAD ANY OF THE FOLOWING OPERATIONS?
IF YES, PLEASE LIST TYPE OF SURGERY AND YEAR PERFORMED

_____ANAL OR RECTAL SURGERY

_____APPENDECTOMY

_____BACK OR SPINE SURGERY

_____ BLADDER SURGERY

_____ BREAST SURGERY

_____ CHEMOTHERAPY

_____ CHOLECYSTECTOMY (GALLBLADDER)

_____ COLON OR INTESTINAL SURGERY

_____ HEMORRHOIDECTOMY

_____ HERNIA REPAIR

_____ HYSTERECTOMY

_____ KIDNEY SURGERY

_____ RADIATION THERAPY

_____ THYROID SURGERY

_____ TONSILLECTOMY

_____ STOMACH OR GASTRIC

_____ EAR, NOSE OR THROAT

_____ OTHER_________________

FAMILY HISTORY

HAVE YOU OR A FAMILY MEMBER HAD ANY OF THE FOLLOWING ILLNESSES?

PLEASE *CHECK* IF YES

ILLNESS	**PERSONAL** (Yes or No)	**Specify**	**FAMILY** (Mother, Father, sister, etc..)	**Specify**
ASTHMA				
BLEEDING DISORDER				
CANCER				
DIABETES				
HIGH BLOOD PRESSURE				
HEART ATTACK OR STROKE				
GLAUCOMA				
GALLBLADDER DISEASE				
HEPATITIS				
THYROID DISEASE				
VENEREAL DISEASE/HIV				
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS?	**NO**	**YES**	**SPECIFY**	
DIGESTIVE/STOMACH PROBLEMS				
DIFFICULTY SWALLOWING				
CHANGE IN BOWEL HABITS				
BLOOD IN STOOL				
BLACK TARRY STOOLS				
LOSS OF APPETITE				
RECENT WEIGHT LOSS				
BLOOD CLOTS				
CHEST PAIN				
SHORTNESS OF BREATH				
PALPITATIONS				
EDEMA (SWELLING)				
BLOOD IN URINE				
PAIN WITH URINATION				
DISCHARGE WITH URINE				
NUMBNESS IN EXTREMITIES				
WEAKNESS				
JOINT PAIN				
RASHES				

WOMEN ONLY

AT WHAT **AGE** DID YOU START YOUR MENSTRUAL PERIODS? ____

AGE AT MENOPAUSE____________________________ DO YOU TAKE BIRTH CONTROL PILLS?____NO____YES

NUMBER OF CHILDREN___________________________ NUMBER OF PREGNANCIES__________________________

HAVE YOU EVER HAD A BREAST BIOPSY? _______NO_______YES

DO YOU TAKE AN ESTROGEN REPLACEMENT? _______NO _______YES

ANY FAMILY HISTORY OF BREAST CANCER? _______NO _______YES

SPECIFY:____