DRS. KHUBCHANDANI, STASIK, BUB

1275 S. CEDAR CREST BLVD., ALLENTOWN, PA 18103 610-433-7571

Today's Date: _____

PATIENT'S NAME: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

Other Treating Physicians: _____

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

Allergy List	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____

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

Drug or Medicine	*Amount/Dose*	*Frequency*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE OR HAVE YOU HAD:

__Y __N Acid Reflux
__Y __N Anxiety Disorder
__Y __N Asthma
__Y __N Atrial Fibrillation
__Y __N Bleeding Disorder
__Y __N Cancer (type)
_____
__Y __N Coronary Artery Disease
__Y __N Coronary Stents
__Y __N Deep Vein Thrombosis (Blood clot leg)
__Y __N Defibrillator
__Y __N Depression
__Y __N Diabetes, Insulin Requiring
__Y __N Diabetes, Non-Insulin
__Y __N Diverticulitis
__Y __N Drug Addiction
__Y __N Emphysema or COPD
__Y __N Fibromyalgia
__Y __N Glaucoma
__Y __N Gout
__Y __N Heart Attack
__Y __N Heart Murmur
__Y __N Hepatitis
__Y __N Hiatal Hernia
__Y __N High Blood Pressure
__Y __N High Cholesterol
__Y __N HIV or AIDS
__Y __N Hypothyroidism
__Y __N Kidney Disease
__Y __N Kidney Stones
__Y __N Leukemia/lymphoma
__Y __N Liver Disease
__Y __N Migraine Headaches
__Y __N MRSA
__Y __N Organ Transplant
__Y __N Osteoarthritis
__Y __N Osteoporosis
__Y __N Pacemaker
__Y __N Peptic Ulcer Disease
__Y __N Peripheral Vascular Disease
__Y __N Pneumonia
__Y __N Poliomyelitis
__Y __N Psoriasis or other skin Disease
__Y __N Psychiatric Disorder
__Y __N Pulmonary Embolism (Blood clot lung)
__Y __N Rheumatoid Disease
__Y __N Seizure Disorder
__Y __N Sleep Apnea
__Y __N Stroke or Mini Stroke (TIA)
__Y __N Tuberculosis
__Y __N Urinary Tract Infections

Please list any other conditions not mentioned above: _____

Do you or anyone in your family have malignant hyperthermia __Y __N

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

HEAD / EAR / 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
__Y __N Other _____

NOSE / SINUSES
__Y __N Hay fever/seasonal allergies
__Y __N Frequent nose-bleeds
__Y __N Other _____

SKIN
__Y __N Skin cancer
__Y __N Itching
__Y __N Wound healing problems
__Y __N Other _____

MOUTH / THROAT
__Y __N Bleeding mouth/gums
__Y __N Difficulty swallowing
__Y __N Dentures
__Y __N Other _____

CARDIAC
__Y __N Frequent chest pains
__Y __N Palpitations
__Y __N Infection of the heart
__Y __N Other _____

PULMONARY
__Y __N Shortness of breath
__Y __N Cough up blood
__Y __N Frequent coughing
__Y __N Wheezing
__Y __N Other _____

OB/GYN
__Y __N History of venereal disease
__Y __N Chance you may be pregnant now
__Y __N Pregnancies #_____ Births #_____
__Y __N 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?_____
__Y __N Other _____

MUSCULOSKELETAL
__Y __N Joint pain
__Y __N Joint swelling
__Y __N Muscle disorder or problem
__Y __N Other _____

NEUROLOGIC
__Y __N Seizure disorder
__Y __N Fainting
__Y __N Numbness arms or legs
__Y __N Paralysis

VASCULAR
__Y __N Aneurysm
__Y __N History of blood clots
__Y __N Other _____

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

PATIENT NAME: _____ **DATE:** _____

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

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed ___Living with significant other

Do you now or have you ever smoked or used smokeless tobacco? ___Y ___N
If yes, how many packs a 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? _____

Do you drink? ___Y ___N
If yes,
_____ Drink _____ Beers per day
_____ Drink _____ wine or liquor servings per day
_____ Social - weekly, weekends
_____ Few times a year only
_____ Alcoholism/Alcohol abuse

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

___ Stroke
___ Heart Disease
___ Diabetes
___ Asthma
___ High Blood Pressure
___ Colon Polyps
___ Colon Cancer
___ Diverticulitis
___ Crohn's Disease
___ Ulcerative Colitis

Cancer:
___ Breast ___ Uterine ___ Ovarian ___ Stomach ___ Prostate

Other forms of cancer _____

****

(For office use only)

UPDATED _____

UPDATED _____

UPDATED _____

UPDATED _____

All systems negative except as marked

_____ MD/DO

_____ DATE