Dr. Susan Schwartz
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IF THERE IS ANY PROBLEM FILLING OUT THIS FORM, PLEASE ASK FOR ASSISTANCE.

Name_____ Birthdate_____ Date_____
Occupation_____ Birthplace_____

FAMILY HISTORY (Has any blood relative had any of the following diseases?)

	Please Circle	Who		Please Circle	Who
Cancer	No Yes		High Blood Pressure	No Yes	
Tuberculosis	No Yes		Bleeding Problems	No Yes	
Diabetes	No Yes		Hearing Loss	No Yes	

PERSONAL HISTORY: (have you ever had the following illnesses?)

Measles	No Yes	Kidney Disease	No Yes
Mumps	No Yes	Gonorrhea or Syphilis	No Yes
Chickenpox	No Yes	Anemia	No Yes
Whooping Cough	No Yes	Jaundice or Hepatitis	No Yes
Scarlet Fever	No Yes	Epilepsy or Seizures	No Yes
Diphtheria	No Yes	Migraine Headaches	No Yes
Smallpox	No Yes	Tuberculosis	No Yes
Pneumonia	No Yes	Diabetes	No Yes
Influenza	No Yes	Cancer	No Yes
Pleurisy	No Yes	High or Low Blood pressure	No Yes
Heart Disease	No Yes	Nervous Breakdown	No Yes
Arthritis	No Yes	Drug or Chemical poisoning	No Yes
Any Bone or Joint Disease	No Yes	Asthma	No Yes
Neuritis or Neuralgia	No Yes	Hives or Eczema	No Yes
Bursitis, Sciatica	No Yes	Frequent infections or Boils	No Yes
Polio or Meningitis	No Yes	Frequent Colds or Sore Throats	No Yes
Fainting Spells	No Yes	Paralysis	No Yes
Enlarged Thyroid or Goiter	No Yes	Enlarged Glands	No Yes
Bleeding Disorders	No Yes	Circulation Problems	No Yes
Herpes/Cold Sores	No Yes		

HABITS:

Alcoholic Beverages: Never____ Barely_____ Moderate____ Daily____
Tobacco: Cigarettes___ packs per day____ Number of years; Cigars__ Pipe___ Chewing Tobacco__ Snuff___

Is the environment in which you work loud or noisy? No Yes

Have you ever been exposed in the past to any Loud or unusual noise? No Yes
Are you exposed to chemicals or have you been? No Yes
Have you been in Military Service? No Yes
Have you ever been involved in a malpractice suit? No Yes

Medications: (list all including aspirin, hormones, diet pills, ect.) ALLERGIES: (list all including Medications, foods tape, ect.)

WOMEN: Last menstrual cycle/ # of Pregnancies_____
SURGERY: (List all operations) Have you ever been hospitalized for any illness: No Yes

Any Medical Problems Not Noted

Referring doctor:
Reasons for seeing doctor:

Patient signature:_____