MARC E. LIEBERMAN, M.D., F.A.C.S.
CONFIDENTIAL PATIENT INFORMATION

Patient's Name (First, Middle, Last)	Sex ☐ M ☐ F	Marital Status ☐ S ☐ M ☐ W ☐ D	Date of Birth	Social Security Number (mandatory)
Permanent Address (Street, City, State, Zip Code)			Home Phone Cell Phone	
Seasonal/Temporary Address (Street, City, State, Zip Code)			Home Phone From Date To Date	
Email Address			Who can we thank for referring you to our office?	
Employer (Company Name)			Work Phone	Calls okay? ☐ Yes ☐ No
Name of person financially responsible (First, Middle, Last)	Social Security #		Date of Birth	Relationship to Patient
Address (Street, City, State, Zip Code)			Home Phone Cell Phone	
If married, spouse's name (First, Middle, Last)			If patient is a minor, name of parent/guardian	
Name of person who does not live with patient to contact in an emergency			Relationship to patient	Phone
If we need to contact you, where can we call? ☐ Home ☐ Cell ☐ Work			Can we leave a voicemail? ☐ Yes ☐ No	

Can we leave a message with other members of the household? ☐ Yes ☐ No
If yes, list names

Name of Referring Physician	Name of Primary Care Physician

MARC E. LIEBERMAN, M.D., F.A.C.S.

MEDICAL HISTORY

Name: _____ Date of Birth: _____

Preferred Pharmacy and Address: _____

Reason for Visit Today & Date of Onset: _____

_____

GOVERNMENT REGULATIONS REQUIRE THAT WE ASK

Primary Language	Race	Ethnicity
☐ English	☐ White	☐ Non Hispanic
☐ Spanish	☐ Black	☐ Hispanic
☐ French	☐ Hispanic	☐ Other
☐ Other	☐ Other	

PAST MEDICAL HISTORY (check Y - yes or N - no)

Y	N	**Cardiovascular:**
☐	☐	High Blood Pressure
☐	☐	Elevated Cholesterol
☐	☐	Coronary Artery Disease
☐	☐	Atrial Fibrillation
		Pulmonary:
☐	☐	Asthma
☐	☐	COPD
☐	☐	Emphysema
☐	☐	Tuberculosis
☐	☐	Sleep Apnea
		Metabolic / Endocrine:
☐	☐	Diabetes Type: _____
☐	☐	Thyroid Deficiency
☐	☐	Thyroid Excess
		Neurologic:
☐	☐	Migraine
☐	☐	Stroke/TIA Year: _____
☐	☐	Dementia
☐	☐	Alzheimer's

Y	N	**Ear / Nose / Throat:**
☐	☐	Hearing Loss
☐	☐	Use Hearing Aids
☐	☐	Chronic Ear Infections
☐	☐	Chronic Sinusitis
☐	☐	Nasal Polyps
☐	☐	Nasal Allergies
☐	☐	Recurrent Tonsillitis
☐	☐	Vertigo/Dizziness
		Musculoskeletal:
☐	☐	Arthritis
☐	☐	Osteoporosis
☐	☐	Osteopenia
		Genitourinary:
☐	☐	Renal Failure
☐	☐	Kidney Stones
☐	☐	Prostate Enlargement
		Hematologic:
☐	☐	Anemia
☐	☐	Bleeding Disorder

Y	N	**Ophthalmology:**
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Macular Degeneration
		Gastrointestinal:
☐	☐	IBS
☐	☐	Hepatitis Type:____
☐	☐	Gastroesophageal Reflux
		Infectious Disease:
☐	☐	MRSA
☐	☐	Mononucleosis
☐	☐	Rheumatic Fever
		Psychiatric:
☐	☐	Anxiety
☐	☐	Major Depression
		Oncology:
☐	☐	Cancer

Type: _____

Others Not Listed Above: _____

_____

Past Surgical History (list with year): _____

_____

Past Hospitalizations (if different from surgery, list with year): _____

_____

☐ **NO MEDICAL/SURGICAL HISTORY**

SOCIAL HISTORY

Government Regulations Require That We Ask

Do you use tobacco? ☐ Never Smoker ☐ Yes If yes, amount per day? _____

☐ Former Smoker When did you quit? _____ When did you start? _____ (year or age)

Do you use alcohol? ☐ No ☐ Yes If you consume alcohol, how often?

☐ 1 time/month ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 times/week

FAMILY HISTORY

Father: ☐ Alive ☐ Deceased at age _____ Cause of death _____

Mother: ☐ Alive ☐ Deceased at age _____ Cause of death _____

Children: ☐ Yes ☐ No If yes, complete:

Number of Sons _____ Healthy? ☐ Yes ☐ No

Number of Daughters _____ Healthy? ☐ Yes ☐ No

FAMILY HEALTH PROBLEMS

(On the line next to the condition, specify:)

M for Mother, F for Father, B/S for Sibling, CH for Child

ADD/ADHD _____
Alcoholism _____
Alzheimer's Disease _____
Arthritis _____
Asthma _____
Blood Disease _____
Cancer _____
Type _____
Coronary Artery Disease _____
Depression _____
Developmental Delay _____
Diabetes _____

Elevated Cholesterol _____
Hearing Deficiency _____
High Blood Pressure _____
Irritable Bowel Syndrome _____
Mental Illness _____
Migraines _____
Obesity _____
Osteoporosis _____
Renal Disease _____
Seizure Disorder _____
Vascular Disease _____
Other _____

☐ **NO FAMILY HEALTH PROBLEMS**

REVIEW OF SYSTEMS - YOUR **CURRENT** MEDICAL CONDITIONS

(check Y - yes or N - no)

Y	N	**General:**
☐	☐	Fever
☐	☐	Chills
☐	☐	Night Sweats
☐	☐	Weight Gain
☐	☐	Weight Loss

Y	N	**Allergy/Immunology:**
☐	☐	Seasonal Allergies
☐	☐	Bronchial Asthma
☐	☐	Bee Sting Allergy
☐	☐	Hives

Y	N	**Eyes:**
☐	☐	Change in Vision
☐	☐	Blurry Vision
☐	☐	Double Vision

Y	N	**Ears:**
☐	☐	Ear Pain
☐	☐	Ear Discharge
☐	☐	Ringing/Tinnitus
☐	☐	Itchiness
☐	☐	Dizziness

Y	N	**Nose & Sinus:**
☐	☐	Sneezing
☐	☐	Runny Nose
☐	☐	Postnasal Drip
☐	☐	Nosebleeds
☐	☐	Congestion
☐	☐	Facial Pain
☐	☐	Mouth Breathing
☐	☐	Decreased Sense of Smell

Y	N	**Throat:**
☐	☐	Sore Throat
☐	☐	Sores in Mouth
☐	☐	Difficulty Swallowing
☐	☐	Hoarseness
☐	☐	Swollen Glands
☐	☐	Sleep Apnea
☐	☐	Snoring

Y	N	**Respiratory:**
☐	☐	Chronic Cough
☐	☐	Coughing Up Blood
☐	☐	Difficulty Breathing
☐	☐	Wheezing
☐	☐	Shortness of Breath

Y	N	**Cardiology:**
☐	☐	Chest Pain at Rest
☐	☐	Chest Pain on Exertion
☐	☐	Swelling - Legs/Ankles/Feet
☐	☐	Pain in Legs when Walking
☐	☐	Rapid/Irregular Heartbeat

Y	N	**Gastrointestinal:**
☐	☐	Blood in Stool
☐	☐	Severe Constipation
☐	☐	Severe Diarrhea
☐	☐	Recently Vomited Blood
☐	☐	Unexplained Nausea
☐	☐	Heartburn

		Hematology/Oncology:
☐	☐	Take Aspirin Regularly
☐	☐	Clotting Disorder
☐	☐	Prolonged Bleeding
☐	☐	Swollen Lymph Glands

		Women Only:
☐	☐	Post Menopausal
☐	☐	Irregular Periods
☐	☐	Vaginal Discharge
☐	☐	Breast Lumps
☐	☐	Genital Herpes

		Men Only:
☐	☐	Difficulty Urinating
☐	☐	Penile Discharge
☐	☐	Genital Herpes
☐	☐	Continuous/ Severe Incontinence

		Skin:
☐	☐	Non-Healing Sores
☐	☐	Change in Size of Mole
☐	☐	Change in Color of Mole
☐	☐	Unexplained Skin Lesions

		Genitourinary:
☐	☐	Abdominal Pain/Swelling
☐	☐	Blood in Urine
☐	☐	Frequent Urination
☐	☐	Pain/Burning on Urination

		Musculoskeletal:
☐	☐	Chronic Back Pain
☐	☐	Joint Pain/Stiffness
☐	☐	Trouble Walking
☐	☐	Joint Trauma

		Endocrine:
☐	☐	Thyroid Disease
☐	☐	Cold Intolerance
☐	☐	Excessive Thirst
☐	☐	Neck Enlargement

		Neurologic:
☐	☐	Difficulty Speaking
☐	☐	Severe Headaches
☐	☐	Frequent Headaches
☐	☐	Memory Loss
☐	☐	Seizures

		Psychiatric:
☐	☐	Anxiety
☐	☐	Depressed Mood
☐	☐	Difficulty Sleeping
☐	☐	Eating Disorder
☐	☐	Substance Abuse
☐	☐	Recent Suicidal Thoughts

Other Medical Condition(s) Not Listed Above:

_____

_____

☐ **NO CURRENT MEDICAL CONDITIONS**