MARC E. LIEBERMAN, M.D., F.A.C.S. and KATSIARYNA HUSEVA BAILOR, M.D.

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

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MEDICAL HISTORY

Name: _____ Date of Birth: _____

Preferred Pharmacy and Location: _____

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	☐ Other	☐ Other
☐ Other		

MEDICAL HISTORY **(check Y box for yes)**

Y Cardiovascular:
- ☐ High Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Coronary Artery Disease
- ☐ Atrial Fibrillation

Pulmonary:
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea

Metabolic / Endocrine:
- ☐ Diabetes Type: _____
- ☐ Hypothyroidism

Neurologic:
- ☐ Migraine
- ☐ Stroke/TIA Year: _____
- ☐ Dementia
- ☐ Alzheimer's

Y Ear / Nose / Throat:
- ☐ Hearing Loss
- ☐ Use Hearing Aids
- ☐ Chronic Ear Infections
- ☐ Chronic Sinusitis
- ☐ Nasal Polyps
- ☐ Chronic Tonsillitis

Musculoskeletal:
- ☐ Arthritis
- ☐ Osteoporosis

Genitourinary:
- ☐ Renal Failure
- ☐ Kidney Stones

Oncology:
- ☐ Cancer

Type: _____

Y Ophthalmology:
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration

Gastrointestinal:
- ☐ IBS
- ☐ Hepatitis Type: ____
- ☐ Gastroesophageal Reflux (GERD)

Infectious Disease:
- ☐ MRSA
- ☐ Mononucleosis

Others Not Listed Above: _____

_____

Past Surgical History (list with year): _____

_____

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

_____

FAMILY HISTORY

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

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

Children: ☐ No ☐ Yes Number of Sons _____ Number of Daughters _____

FAMILY HEALTH HISTORY

On the line next to the condition, specify:
M for Mother, F for Father, B/S for Sibling, CH for Child

Alzheimer's Disease _____
Arthritis _____
Cancer _____
Type _____
Diabetes _____
Heart Disease _____
High Blood Pressure _____
Kidney Disease _____
Parkinson's Disease _____
Respiratory Disease _____
Other _____

☐ **NO FAMILY HEALTH PROBLEMS**

REVIEW OF SYSTEMS - YOUR CURRENT MEDICAL SYMPTOMS (check Y for yes)

Y General:
☐ Fever
☐ Chills
☐ Weight Gain
☐ Weight Loss

Nose & Sinus:
☐ Sneezing
☐ Runny Nose
☐ Postnasal Drip
☐ Congestion
☐ Facial Pain
☐ Nosebleeds

Cardiology:
☐ Chest Pain or Pressure
☐ Shortness of Breath
☐ Swelling - Legs/Ankles/Feet
☐ Pain/Cramping in Legs
☐ Palpitations/Arrythmia

Hematology/Lymphatic:
☐ Abnormal Bleeding
☐ Bruise Easily
☐ Anemia

Endocrine:
☐ Cold Intolerance
☐ Excessive Thirst
☐ Neck Enlargement

Y Allergy/Immunology:
☐ Seasonal Allergies
☐ Bee/Wasp Sting Allergy
☐ Receive Allergy Shots

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

Gastrointestinal:
☐ Heartburn
☐ Bloody Stool
☐ Severe Constipation
☐ Severe Diarrhea
☐ Recently Vomited Blood

Skin:
☐ Non-Healing Sores
☐ Changing Mole(s)
☐ Rashes
☐ Unexplained Skin Lesions

Neurologic:
☐ Difficulty Speaking
☐ Dizziness
☐ Numbness/Tingling
☐ Seizures

Y Ears:
☐ Ear Pain
☐ Ear Drainage
☐ Ear Itchiness
☐ Ear Ringing

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

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

Musculoskeletal:
☐ Chronic Back Pain
☐ Chronic Neck Pain
☐ Trouble Walking

Psychiatric:
☐ Anxiety
☐ Depressed Mood
☐ Substance Abuse
☐ Recent Suicidal Thoughts

SOCIAL HISTORY Government Regulations Require That We Ask:

Do you use tobacco? ☐ Never Smoker ☐ Yes If yes, please answer questions below

☐ 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

TOBACCO USE

How many cigarettes a day do you smoke?

☐ 5 or less
☐ 6 to 10
☐ 11 to 20
☐ 21 to 30
☐ 31 or more

How soon after you wake up do you smoke your first cigarette?

☐ within 5 minutes
☐ 6 to 30 minutes
☐ 31 to 60 minutes
☐ after 60 minutes

Do you use any tobacco products listed below?

☐ chewing tobacco
☐ pipe

Are you interested in quitting smoking/tobacco use?

☐ ready to quit
☐ thinking about quitting
☐ not ready to quit